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Framework for involving patients in patient safety consultation: NHS Providers response

About NHS Providers

NHS Providers is the membership organisation for the NHS hospital, mental health, community and ambulance services that treat patients and service users in the NHS. We help those NHS trusts and foundation trusts to deliver high-quality, patient-focused care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate.

NHS Providers has all trusts in voluntary membership, collectively accounting for £87bn of annual expenditure and employing more than one million staff.

Key points

- The draft framework provides useful, thorough and practical support to help providers support patients to be partners in their own safety as well as the safety of an organisation. The framework offers a positive focus on enabling and sharing learning, in line with the overarching ambition of the Long Term Plan to better support providers and foster a culture of continuous learning. Alongside this, the framework also acknowledges the importance of locally owned solutions which reflect the needs of patients, rather than a 'one-sizes-fits-all' approach.

- It is helpful that the framework cross-references connected policies related to the NHS Patient Safety Strategy. Mapping how this framework sits alongside other work happening at a national level in patient engagement and feedback would add further benefit.

- Our main concern focuses on how much time and resource will be needed to implement the framework. We believe that national bodies and local organisations would benefit from understanding why variation in approach exists, what barriers there are, and what role it may

be helpful for the national patient safety team and other national bodies to play in identifying and helping to surmount these.

- There are a number of providers who engage patients in patient safety well; the development and launch of this framework provides an opportunity to share deeper insights on the approaches that work, the level of resources and time invested and the lessons learned to further help those who are committed to improving their own approach locally.

Our response

Does the draft Patient Safety Partner Framework provide sufficient guidance about supporting patients to be involved in their own safety?

The guidance within the framework is very thorough and reflects efforts by NHS England and NHS Improvement to meet the needs of those at a local level, who will be responsible for putting this into practice.

Providers will find it extremely helpful to have access to example policies and guidance to adapt for local use and the inclusion of case study examples within the framework from organisations that are further along in this work is valuable, showcasing the commitment to meaningful patient involvement. We feel there is value in illustrating how this framework can be embedded successfully, given the differing levels of maturity between organisations in this work.

Overall, the framework has a positive focus on enabling and sharing learning which is a helpful approach and in line with the overarching ambition of the Long Term Plan to better support providers and foster a culture of continuous learning. This also acknowledges the importance of locally owned and shaped solutions which reflect the needs of patients, rather than a one-size-fits-all approach.

We are aware of work happening nationally led by other organisations that aim to also help create a positive and open approach to patient feedback and involvement, such as the Complaints Standard Framework from the PHSO. We believe it would be helpful to coordinate these efforts towards patient safety to ensure no conflicts in messaging or duplication of effort arise.

We note that several policies connected to the NHS Patient Safety Strategy are cross-referenced; this is helpful in helping providers make sense of the complicated landscape in patient safety policy. We also welcome the articulation of the context for this work in reference to Don Berwick's 2013 report, 'A promise to learn, a commitment to act'.

Are there any challenges to involving patients more in their own safety that we have not recognised?

The content and information in this first part of the framework represents a helpful route-map to aid providers in embedding patient involvement in patient safety in a meaningful way. However, our main concern is the reality of how much time and resource will be required to undertake this task properly. We also suggest that more work needs to be done to understand why variation in approach exists amongst providers: a better understanding of what barriers exist to driving further improvement, and what role it may be helpful for the national patient safety team and other national bodies to play in identifying and helping to surmount these would be useful.

We think the main challenges with the framework will lie in facilitating and enabling the changes required for it to be delivered. Regulation pressures, misaligned requirements around reporting, bureaucratic burden, local variation, and workforce shortages will all present barriers to delivering the framework. Whilst recognised as deeply important, this work will be competing against the large number of asks being made of the system, a situation made more pressing due to COVID-19.

We note that the framework recognises that the pace of change will be different for each provider depending on their local circumstances. This is welcome, and further support in terms of shared learning from those further ahead, and greater illustration of the role this work could, and has, played for others in helping meet wider leadership, culture and transparency ambitions would build on this.

The framework includes useful guidance in several areas, for instance around developing local patient safety campaigns. It may be helpful to identify where providers may need more guidance to develop the expertise they need to know where to focus and prioritise efforts in what can be a very wide ranging field of safety, and where support from elsewhere in the system may be found, for instance through the Patient Safety Collaboratives and other improvement initiatives underway.

It is also noted in the framework that further alignment will be needed as other national work develops namely the Patient Safety Syllabus and the new Patient Safety Incident Management System, which will replace the National Learning and Reporting System. It is vital that this is done clearly and

in a timely fashion and that the different areas of work are clearly aligned and how they contribute to the wider ambitions made clear.

Do you agree with the principles of how Patient Safety Partners should be involved in an organisation's patient safety work?

We agree with the principles of how Patient Safety Partners should be involved in an organisation's patient safety work. With regard to principle three - Inclusive approaches to Patient Safety Partners – it is absolutely right, and indeed essential to a robust and meaningful approach, to reflect the diversity of the local community. We note that trusts may welcome additional support and learning from those progressing well against this principle to enable them to deliver on this, especially given that research shows that diverse recruitment can be challenging. It will also be important to ensure that vulnerable groups feature fully in this programme, including those with multiple and complex care needs, learning disability users, children, people from deprived communities, and the elderly.

Do you agree generally that organisations should not appoint employees as Patient Safety Partners?

One of the greatest values in involving patients in patient safety work is the fresh and different perspective they bring. As such, we believe that this could be diluted should employees be appointed as Patient Safety Partners. We therefore agree that generally this would not be advised although trusts should be offered the flexibility to make exceptions where, for example, staff members who are also patients can bring a useful perspective.

Does the draft framework provide sufficient guidance to help organisations to introduce Patient Safety Partners in order to support their patient safety work?

As with the guidance provided to enable patients to play a role in their own safety, the information within the framework for organisations is very thorough and this approach is appreciated. As mentioned previously, it's extremely helpful for providers to have access to example policies and guidance to adapt for use locally. With regard to turning the principles into practice, the advice is clear and helpful.

We would like to highlight a few key points that could be considered going forward:

- Managing Patient Safety Partners based on principles of equality and diversity is absolutely the correct ambition. However, it is clear, from the on-going recognition that more needs to be done to help ensure equality in the health system both in staff and patient experience,

particularly for those from Black, Asian and Minority Ethnicity groups, that this is an area in which the NHS needs to improve. This should be reflected and acted upon within this framework, especially given the recognised relationship of power dynamics and the ability to speak up and the intrinsic importance of harmoniously supporting Patient Safety Partners to provide what may be very different and challenging perspectives.

- We note that an example of a potential Patient Safety Partner is someone who may have experienced 'avoidable harm'. Given the draft Patient Safety Incident Response Framework encourages 'avoidability' to be abandoned as an outcome measure and cites the terms 'avoidable' and 'unavoidable' as unhelpful for patient safety, it would be helpful for the language used to align across initiatives.

- The current draft framework does not stipulate a minimum time commitment from Patient Safety Partners, which is a welcome reflection of the need for local providers to shape patient involvement to best suit their needs. However, the approach, whilst being robust and in the right spirit of meaningful involvement, is necessarily time consuming for patients, as well as staff. There is a risk that this could lead to high rates of turnover and short tenures from Partners as a result, and will add expectations to already overstretched staff. This is an area where it may be particularly useful to share learning from those organisations who excel at patient involvement, with useful insight to share with those earlier on in this journey, to help manage these risks.

- Local providers are expected to create their own measures for patient involvement. They may benefit from additional clarity and guidance on how to assess the degree to which the intended benefits are occurring, or the degree to which patients have been usefully involved in the process. Such insight and guidance will help to ensure that patient involvement is meaningful. In terms of measuring the impact, it is important to note that there is value in measuring and evaluating both qualitative and quantitative data for improvement.

- In developing the Patient Safety Partner roles and task profiles, we note that the framework encourages a cross organisation approach, involving HR, finance and operations. We agree, and also recognise this as a good chance to embed positive processes and procedures that support a just and learning culture, since successful involvement of patients in patient safety relies on the behaviours and attitudes of individuals across an organisation as a whole. It may be useful to further outline how, in assessing readiness, an organisation may choose to align or coordinate this project with other, wider cultural ambitions such as encouraging an open and learning culture.

- We note that there is an expectation that Patient Safety Partners could be involved in the development of a relevant patient safety strategy and policy. Whilst we fully agree that this

ambition carries with it great potential value, we must highlight that given this is a new approach for some, some local staff may need more support than others to develop the skills to enable the fresh perspectives Patient Safety Partners can bring. Patient Safety Partners will also need to be supported to help them understand the unique challenges in healthcare and the dilemmas and risk in managing safety in a complex system, alongside measures to ensure they do not become too deeply influenced by existing approaches of an organisation.

Do you agree it is achievable for organisations to have two Patient Safety Partners on each safety related clinical governance committee (or equivalent) by April 2021?

Whether this is achievable or not may differ from organisation to organisation; each will be working under different local pressures that may impact on the ability to meet a set deadline. In particular, the current situation, given the on-going uncertainty with the COVID-19 pandemic, may make it more difficult than initially anticipated for trusts to successfully engage potential Patient Safety Partners. Also, any further waves of infection may have an impact on available resource to prioritise this work either nationally or due to regional spikes.

As highlighted by principle three in the draft framework, it is important that Patient Safety Partners should represent the local population. As detailed earlier in this submission, finding representatives with the time and confidence to take part could potentially be more difficult in some areas than others. In some local areas, trusts will need to learn from partners with a long history of engagement such as local authorities, to find innovative ways to reach and engage with people from different communities. This may mean taking advice from local community leaders, understanding cultural, religious and ethical considerations and ensuring they can communicate with people whose first language is not English. The NHS is on a journey with regard to improving inclusivity and tackling inequality. We know that securing diverse voices to inform improvement activity has been challenging in the past, and we are keen to ensure trusts receive the support they need to make a step change here. For instance, the frail, elderly and non-English speaking patients are often under-represented, which has an impact on the insights generated for improvement. Trusts need to ensure the requirements of all those participating are met. We suggest it would be helpful to trusts for this challenge to be recognised, although we appreciate that recruiting two partners is seen as a starting point from which to build.

To complement the insight that Partners could bring, it will be important to provide organisations with the resources and knowledge on how to bring together and make best use of the mass of data

that is already available in terms of patient experience, to which this will add. Patient involvement data has been described as "one small part of an ever-growing tsunami of data that we collect in health services", with challenges around the time and resources available to devote to understanding and interpreting it. It has also been highlighted in research literature that one patient or even several may not represent the view of all.

We estimate organisations may need to invest around £6,000 per year in Patient Safety Partner work. Do you agree with this estimate?

It must be noted that the full cost of initiatives such as Patient Safety Partners is not only monetary in nature. To do this well takes time and resources which ultimately also have a cost, which are not fully included in the estimated figure, for instance day to day involvement in a given project will take additional staff time as well as the quarterly and monthly support meetings proposed. It may be helpful to investigate and share insight on the total costs, time and resources experienced by those further ahead in this work.

Is this investment of resources reasonable and achievable for trusts/providers?

This may differ depending on sector and between providers, impacted by the wider financial context they find themselves in.

The draft framework identifies a number of elements of training that we think Patient Safety Partners would benefit from. Do you agree with these?

Training should help Patient Safety Partners to understand both the organisation and the wider environment, alongside an understanding of patient safety and the barriers and dilemmas faced by staff in delivering high quality care in complex situations. Overall, the level of training required may differ from Partner to Partner depending on the tasks and level of involvement they face and will need to take stock of their existing knowledge and experience.

All training regarding patient safety should align with the messages and theories included in the forthcoming patient safety syllabus to help ensure a shared understanding between all parties. We also recognise, as outlined above, that supporting Patient Safety Partners to know enough to contribute meaningfully, whilst maintaining their unique viewpoint from outside the system, may take particular skill from staff members. Given our comments on principle 3, consideration of training and support to engage with representative patient groups may be of benefit.

We suggest that organisations further long in this work may have useful insight to share.

Do you agree that the potential roles for Patient Safety Partners to support an organisation's patient safety are appropriate?

It's useful that the framework identifies potential ways in which Patient Safety Partners can contribute to an organisations patient safety work. As with other elements of the framework, local providers may benefit from understanding how others have succeeded in doing this well. It will also be important for the training provided for Partners to meet their needs to ensure they can contribute meaningfully, and for staff so that they can support appropriately. Flexibility locally will also be key, as trusts may have unique needs and therefore require the ability to meet these in ways that work for their context. They may also find alternative ways to work in partnership with patients, with benefits for both Partners and the organisation.

Further comments on the draft Framework for involving patients in patient safety:

With the right support for organisations locally, patient involvement could play a role in helping to realise the ambition in the NHS Patient Safety Strategy to move "from talking about harm to talking about safer systems that provide the right care, as intended, every time and learning from what works, not just what does not."

Risk management is currently retrospective, where safety is defined as the absence of harm. This means that, according to research, much patient feedback doesn't actually 'fit'. In such studies, retrospective feedback on incidents reportedly tend to relate more broadly to quality than safety.

Patients also often give positive feedback, which could help the system learn from the presence of safe, high quality care. The perspective of Patient Safety Partners on what is working, coupled with learning from what isn't, could help in this realignment of safety.

Positive feedback is also important for staff morale. We know that a number of our members have in place processes for recognising and sharing good practice, for instance Learning from Excellence. Again, there is a relationship to enabling a different view of safety, as part of a positive, proactive safety culture which avoids an over-focus in failure at the expense of learning from what goes well.

With this in mind, we suggest it may be helpful to our members if NHS England and NHS Improvement further explore the relationship of patients as partners to the ambition to achieve a more balanced approach to safety and a just culture.

It is also important to note that patient experiences do not neatly configure to the boundaries of our organisations, structures and role definitions. To really capture and understand experience as it happens for patients, these distinctions may need to be side-lined. In addition, the period of transition from one healthcare setting to another has also been shown to be a risky time for patients. We would encourage NHS England and NHS Improvement to consider if the draft Framework provides sufficient guidance on this challenge for local providers, and alignment with other work to develop a programme of support for systems around public participation that we understand is in progress. It will be helpful, as system work develops further, for local organisations to be supported to understand how involving patients in patient safety could contribute to better system-wide learning, collaboration and cohesion.