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A new approach to patient safety for the NHS

Patient safety is changing in the NHS, moving towards an approach that embraces system learning – is your trust going to be ready in time?

The NHS is in the process of changing the way it embraces patient safety, moving from a focus on individual incidents and issues to a more comprehensive look at system learning.

The changes are set out in NHS England/Improvement's Patient Safety Strategy, released in July 2019 and updated in February 2021. This was followed by the Patient Safety Investigation Framework in March 2020, due for full implementation by Spring 2022.

They are important not just in relation to incident management but also because of the implications they have for strategy and board responsibilities in relation to patient safety. So they need careful attention at all levels of NHS organisations.

Safety roles and responsibilities

There is a move towards an approach based on patient safety partners – members of the community, supported by board members, who should be involved in incident management, pathway design, governance and the patient safety strategy. This brings direct community involvement into organisational thinking in a way that is enforced.

Some organisations already do this well, with co-designed/produced work with stakeholders. For others, it will be a big step and they should learn lessons from others in how to make it a positive change that is not purely consultative but adds real value.

Trusts will need to have trained and appointed patient safety specialists. These are similar to Caldicott Guardians or directors for infection, prevention and control, so it will be a role for an existing staff member. It is key that this role is integrated into patient safety networks, set up to share best practice and learning.

There is also a move away from the standard root cause analysis way of investigating incidents towards an approach based on training in a patient safety syllabus. This will cover the investigation requirements of the Patient Safety Investigation Framework. Trusts should ensure they have the right people and capacity trained by April 2022 (unless they are early adopters) to implement the framework.



Moving to a proactive approach to safety management

Beyond some of the role and methodology changes is a shift in emphasis towards Safety II, a proactive approach that focuses on what prevents optimal safety and how to work collaboratively to improve. So trusts need to start looking not just at taking action over incidents that have already occurred but also looking at what could occur in the future. This will require more focus on near-miss and no-harm incidents than before.

There is a refocus on the just culture toolkit, via work on psychological safety. This is similar to work done over ten years ago via the Manchester Patient Safety Framework and Texas Safety Culture survey, encompassing team culture, diversity and inclusion, compassionate leadership, and openness to learning.

In many Academic Health Science Networks (AHSNs), a trial of the SCORE (safety, communication, operational reliability and engagement) survey was used in maternity services to reintroduce patient safety culture. Trusts will need to consider this and other options for assessing how they can assess and improve safety culture going forward.

All of the above will need to be built into a patient safety response plan that is signed off by the board. This should be a proactive plan highlighting what types of incidents you are going to focus resource on and what tools you will use to do this. This will be in replacement of the old serious incident framework where particular types of incidents had to be reported.

Welcome changes

The changes should be welcomed as long as the focus at national and system level remains on improvement and learning and does not relapse too much to timescales and template completion.

Bringing this area with specific board attention is understandable but it should be noted that there are many detailed roles and responsibilities that boards need to sign off and oversee. Patient safety feels appropriate but a review of what should be signed off at board is needed to prevent boards becoming overburdened.

Boards need to think early about how their organisations will be putting this into practice while also having the right degree of oversight. Key will be scrutinising how the trust is changing its safety culture in line with national requirements, with that focus on system learning and innovation.

GGI is already working with trusts to help them review their quality governance structures ahead of the national changes, as well helping them to figure out what this means for internal policies, procedures and approaches in the interim.

Illuminations

- Boards should ensure they are briefed on the patient safety strategy changes and their implications, including what changes the trust will be making to implement them.
- Trusts should already be reviewing their current structural and policy arrangements for patient safety and incident management in preparedness for the changes by April 2022.
- Trusts should consider what external support they may need to implement the changes, including speaking with early adopters.

GGI has many years of experience in supporting organisations with clinical governance, including patient safety. If you would like any help or support with any of the issues raised in this briefing, please call us on 07732 681120 or email advice@good-governance.org.uk.