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Submitted to **Developing a patient safety strategy for the NHS**
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Your details

1 What is your name?

Name:
Peter WALSH

2 What is your email address?

Email:
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3 Are you responding as an individual or on behalf of an organisation?

An organisation

4 If responding on behalf of an organisation, which organisation do you represent?

Organisation:
Action against Medical Accidents (AvMA)

5 If responding as an individual, in what capacity/role are you answering (eg as a patient, carer, NHS member of staff, academic etc.)?

Role/capacity:
Chief Executive

Proposed aims and principles

6 Do you agree with these aims and principles?

No

Please explain your answer:
If there was the option I would say 'partially'. We do not disagree with the principles as far as they go, however they are not well defined. There is also a principle that is missing. That is that certain actions to safeguard patient safety should be mandatory. Yes we need to win hearts and minds and yes we need training and support for staff, but there need to be some bottom lines for organisations in particular. We should not be afraid to say that organisations need to be held to account for not following good practice or not implementing patient safety alerts, for example, or not complying with the duty of candour. Monitoring and regulation are vital parts of the equation.

7 What do you think is inhibiting the development of a just culture?

Please provide details:
Failure to act on past recommendations of inquiries etc

Delay in setting up the just culture task force

Promotion of policies which go against the principles of a just culture (eg, 'safe space' investigations, fixed costs in clinical negligence

Lack of funding

8 Are you aware of our 'Just Culture Guide'?

Yes

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

Please provide details:
To be honest calling the resource a 'Just Culture Guide' is a little misleading. It is a useful tool, which we endorsed, but all it does is help decision making with regard to how much individual staff are dealt with.

We need the promised Just Culture Task Force to be convened.

The task force should include strong patient representation (both individual patients/family members and patients organisations.

Just Culture needs to be defined. The definition should make it absolutely clear that a just culture in the NHS applies to everyone. The way that injured patients are treated after a patient safety incident is just as much part of this as the way staff are treated.

The task force should make recommendations about what structural, systemic or policy changes are needed to support a just culture.

10 What more should be done to support openness and transparency?

Please provide details:
Development of the just culture as above, together with zero tolerance of failing to comply with the duty of candour, or of treating whistleblowers unfairly or bullying.

There should be system wide training on the duty of candour funded and provided via the centre.

Commissioners and regulators need to be seen to be monitoring compliance with the duty of candour much more proactively and rigorously.

11 How can we further support continuous safety improvement?

Please provide details:

Insight

12 Do you agree with these proposals?

No

Please explain your answer:
Only partially agree. We need to have a much more joined up approach. More and more 'insight' is little use unless it is translated into real change to improve patient safety.

13 Would you suggest anything different or is there anything you would add?

Please tell us if you have any suggestions:
As above - a more joined up approach that sees real change delivered as a greater priority than gaining more data and insight. This means supporting organisations to change and a robust regulatory approach when mandated actions are not implemented.

Infrastructure

14 Do you agree with these proposals?

No

Please explain your answer:
Only partially agree. We certainly agree with the idea of a national patient safety curriculum. It is something we have long called for. Also the development of senior patient safety specialists and a patient safety support team. The "patient advocates for safety" proposal is welcome in that it at least acknowledges the need to involve patients more in patient safety. However, there is no detail as to the rationale for this in the document, the role of the advocates, or how they will be supported. Frankly, we are staggered that NHS Improvement has not discussed this with AvMA at an early stage. We have been the main champions of patient involvement in patient safety for years and partnered the NPSA in developing and managing the 'patients for patient safety' and 'patient safety champions' projects. It is imperative that we learn from the experience of these initiatives, as well as approaches in other parts of the world.

This idea seems to have found its way into the draft strategy without reference to or consideration of the Learning from Deaths programme either. One of the main findings of this work was the need to support the involvement of patients / families in investigations by making specialist independent information, advice and where appropriate, advocacy available.

15 Would you suggest anything different or would you add anything?

Please tell us if you have any other suggestions:
See above and below.

16 Which areas do you think a national patient safety curriculum should cover? Select your top five answers only.

Introduction to patient safety science, Patient/family/carer engagement, NHS patient safety systems, The components of a patient safety culture

Please provide details of any other areas:
The duty of candour

17 What skills and knowledge should patient safety specialists have? Select your top five answers only.

Patient safety science, Human factors and ergonomics, Safety investigation, NHS patient safety systems, The components of a patient safety culture

Please provide details of any others:

18 How senior should patient safety specialists be?

Not Answered

19 How can patient/family/carer involvement in patient safety be increased and improved?

Please provide details:
Patients, families or carers need to be involved in different ways and at different stages. These include being fully involved in making informed choices about treatment; understanding risks; helping ensure their own safety; being fully involved (and empowered in) safety investigations; and being involved in local, regional and national oversight of patient safety strategy and development work.

20 Where would patient involvement be most impactful?

Patient to clinician (1:1) level, Clinical pathway design and management level, Provider or local system clinical governance/quality oversight level, Whole system/strategic level, Other (please provide details below)

Please provide details of any other areas:
Patient safety investigations. The recent Learning from Deaths programme work emphasised the need to support the involvement of families in investigations by making specialist independent information, advice and where appropriate, advocacy available. However this need is not restricted to fatal cases. Various guidance including that for the Serious Incident Investigation Framework and Duty of Candour refer to independent advice and/or advocacy for patients/families. Yet there is no central funding for such services.

The need was also flagged up by Sir Robert Francis in his report on the Mid Staffordshire NHS Foundation Trust Public Inquiry. (3.132, 3.133, 3.134).

More recently reports by the CQC and by NHS Resolution have found very low levels of patient/family involvement in safety investigations. This is not just about 'letting them in'. Most patients/families need specialist independent advice and support to be able to take part meaningfully in investigations.

Whilst we would welcome various initiatives to support patient/family involvement, this is probably the most pressing area of need. It tends to be overlooked for more comfortable and general involvement of patients. If patients/families are not empowered to be fully involved in investigations when things go wrong, it is difficult for people to have confidence in other involvement activities.

21 Would a dedicated patient safety support team be helpful in addition to existing support mechanisms?

Yes

Please explain your answer:

Initatives

22 Do you agree with these proposals?

No

Please explain your answer:
Agree but only partially. Some of these are very worthwhile initiatives. We would welcome a more involved discussion about the relative merits of each

23 Would you suggest anything different or would you add anything?

Please tell us if you have any other suggestions:

24 What are the most effective quality improvement approaches or delivery models? Select your top three answers only.

Please tell us of any others:

25 Which approaches for adoption and spread are most effective? Select your top three answers only.

Mandating standardised processes/approaches, Demonstrating evidence of impact and value, A national or regional spread programme

Please provide details of any others:

26 How should we achieve sustainability and define success?

Please provide details: