PSNC response to NHS Improvement's proposals for consultation – Developing a patient safety strategy for the NHS

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Introduction

The Pharmaceutical Services Negotiating Committee (PSNC) promotes and supports the interests of all NHS community pharmacies in England. We are recognised by the Secretary of State for Health and Social Care as the body that represents NHS pharmacy contractors. We work closely with Local Pharmaceutical Committees (LPCs) to support their role as the local NHS representative organisations.

Our goal is to develop the NHS community pharmacy service, and to enable community pharmacies to offer an increased range of high quality and fully funded services; services that meet the needs of local communities, provide good value for the NHS and deliver excellent health outcomes for patients.

We welcome the opportunity to be able to provide our response to the proposals set out in NHS Improvement's consultation document on developing a patient safety strategy for the NHS.

Response

We welcome the development of a national patient safety strategy, aligned to the NHS Long Term Plan. We support the proposals set out in the document and believe the underlying principles are clear, appropriate and they align well with the principles that community pharmacies have been applying in recent years, which have been developed and championed by the Community Pharmacy Patient Safety Group.

We do however believe the strategy, as currently written, is rather focused towards secondary/in-hospital care; the document would benefit from further examples of the approaches to patient safety improvement that have been rolled out across other parts of the health and care system, including in community pharmacy.

Consultation questions

1. **PRINCIPLES**

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

   We support the three overarching aims of the strategy and the three principles that should underpin implementation.

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

   The understanding of what a just culture means in practice is not clear to all healthcare professionals and their teams. Just culture can be quite complex and sometimes subjective, so it is important that all individuals have a good understanding of the principles which underpin a just culture. Additionally, previous experiences and treatment of staff which were unjust, can inevitably affect an individual's future approach to open reporting and sharing behaviour.

   Some community pharmacy owners have reported a lack of acceptance or understanding of just culture by some families and patients who have been affected when a patient safety incident occurs; this can again impact on the future willingness of staff to adopt open reporting and sharing behaviours.

   c. **Are you aware of A just culture guide?**

   Yes.

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

We believe the development of a just culture is fostered through ensuring individuals at all levels of the organisation understand what a just culture means in practice. Organisations can work to achieve this by ensuring that learning about a just culture is built into the training of all relevant staff.

It is not always clear to patients and the public what actions are taken within an organisation when a patient safety incident occurs. Information for the public to drive better understanding of the actions and steps that are usually taken by individuals, employers and regulators when incidents occur would be valuable. We believe it would be helpful for a clear document, aimed at patients and the public, to be published which outlines the purpose and aim of different types of investigations. This would support professionals and organisations in carrying out good investigations whilst helping to meet patient and family needs and expectations.

It would also be useful for healthcare professionals and organisations to have access to examples or case studies which demonstrate good practice in the application of a just safety culture.

e. What more should be done to support openness and transparency?

A willingness to openly talk about and share learning and best practice is very important. Multi-professional sharing and effective communication across organisations is also important, in particular between community pharmacy teams and other care settings, e.g. general practice or NHS trusts. Such sharing and communication may be better enabled by the development of Primary Care Networks across England if they can be used to fully engage all health and care providers in discussions on patient safety across the network.

The Quality Payments Scheme within the NHS Community Pharmacy Contractual Framework has already incentivised community pharmacy quality improvement activity focused on patient safety; further development of that scheme could be used to support more reporting and sharing of information on patient safety incidents and learning from those incidents.

f. How can we further support continuous safety improvement?

Receiving useful feedback following the reporting of incidents is key to driving improvement and also motivating staff to keep up reporting activity; this is an important role for NHS Improvement's patient safety team, which should be appropriately resourced.

Effective continuous safety improvement requires learning and best practice to be shared across networks to seek to reduce the reoccurrence of patient safety incidents; as noted above, supporting such learning and collaborative working could be an important role for Primary Care Networks.

2. INSIGHT

a. Do you agree with these proposals? Please give the reasons for your answer

Yes. We particularly hope that the PSIMS will help increase reporting levels and improve the identification of learning from patient safety reports.

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

The recently announced changes to the GP contract include a requirement for general practices to register an email address with the MHRA in order that safety alerts may be sent directly to practices rather than via the cascade route through NHS England or CCGs. It would be helpful if a similar approach could be taken to distribution of alerts to community pharmacies, so that alerts are always received in a timely manner.

3. INFRASTRUCTURE

a. Do you agree with these proposals? Please give the reasons for your answer

Yes. We are particularly supportive of the proposal to appoint patient safety advocates and a dedicated patient safety support team. This team of experts should be easily accessible to all providers of NHS-funded care who may benefit from their expertise, including community pharmacy teams and Medication Safety Officers.

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

No.

c. Which areas do you think a national patient safety curriculum should cover?

The curriculum should be illustrated by both patient and healthcare professional perspectives and stories from multiple healthcare settings, not only secondary care settings. The content should include human factors and the importance of effective communication.

d. How should training be delivered?

The training must be practical rather than theoretical and should therefore involve practising healthcare professionals from design through to implementation and include case studies and examples from many different healthcare settings. Online training can be beneficial if the content is engaging, e.g. use of animations and videos.

e. What skills and knowledge should patient safety specialists have?

Patient safety specialists should be experienced and trained in good investigation skills, root cause analysis, risk management and assessment. It would be beneficial for these individuals to have personal experience of working in healthcare environments, so they can better understand the challenges professionals face around culture, systems design, communications and professional decision-making.

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

Involving patients in the delivery of training (e.g. via videos), which allows trainees to learn about real patient stories, could be very useful. It would also be valuable for training to include videos of patients describing how they would like to be treated throughout an investigation of a patient safety incident.

As noted above, publication of a clear document for patients and the public which outlines the purpose and aim of different types of investigations could help patients, family members and carers to understand what processes may follow a patient safety incident and the role they can play in these processes.

g. Where would patient involvement be most impactful?

Patients and the public should be involved in national work undertaken by NHS Improvement to develop safety alerts and solutions to identified patient safety problems.

h. Would a dedicated patient safety support team be helpful in addition to existing support mechanisms? If yes, how?

Yes. The dedicated patient safety support team could provide additional resource to that currently available to healthcare providers, particularly those in primary care, to support patient safety improvement activity and sharing of learning across the country.

4. INITIATIVES

a. **Do you agree with these proposals? Please give the reasons for your answer**

We agree with the proposals to commit to reducing measurable harm by 50% through specific targeted initiatives. and we recommend that the Community Pharmacy Patient Safety Group should be closely involved as the final interventions and priorities for the work aligned to the Medication Without Harm challenge are decided.

b. Would you suggest anything different or do you have anything to add?

No.

c. What are the most effective improvement approaches and delivery models?

The community pharmacy Medication Safety Officers have found it to be most effective when national patient safety alerts give clear and defined expectations for different groups of healthcare professionals, as this supports consistent interpretation and implementation of any improvement methodology.

d. Which approaches for adoption and spread are most effective?

We believe collaborative working is fundamental to driving system-wide change and the Patient Safety Collaboratives should support healthcare organisations to partner and learn from each other across, Primary Care networks, regions or nationally.

e. How should we achieve sustainability and define success?

There are many ways to encourage sustainable quality improvement but ensuring healthcare providers see positive developments as a result of reporting patient safety incidents can provide motivation to keep working on minimising patient safety risks and sharing information on incidents.

Financial incentives delivered through NHS contracts can also support ongoing engagement and continuous improvement in practice, by providing additional financial resources to support this work. As one example, in 2017 the community pharmacy Quality Payments Scheme incentivised 10,766 community pharmacy contractors to produce a reflective safety report specific to each pharmacy.