NHS Resolution response to the [consultation on the Framework for Involving Patients in Patient Safety](file:///%5C%5CDriveShare1.Resolution.Online%5CBusiness%20Development%5CPolicy%20work%5CConsultation%20%26%20Inquiries%5C2020-21%5CNHS%20Improvement%20-%20Framework%20for%20involving%20patients%20in%20patient%20safety%5CFramework%20for%20involving%20patients%20in%20patient%20safety%20-%20FINAL%20draft.docx)

1. NHS Resolution
2. anna.manning@resolution.nhs.uk
3. We are responding as an organisation.
4. NHS Resolution.

NHS Resolution handles claims for compensation which arise for a variety of reasons, such as clinical errors, employee injuries and accidents on NHS premises. In addition to this, our Safety and Learning team works closely with NHS care providers to identify and target areas for improvement and ensure that learning is shared and implemented to improve safety standards across patient care and our Practitioner Performance Advice service protects patients and public funds by managing concerns about practicing clinicians without unnecessary exclusions and suspensions.

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

Yes

1. **Are there any challenges to involving patients more** i**n their own safety that we have not recognised?**

Yes. We recognise the following challenges:

* **Staff challenges when things do not go as expected or planned** - NHS Resolution published Being Fair[[1]](#footnote-1) which sets out the case for organisations adopting a more reflective approach to learning from incidents and supporting staff. It identified three main challenges for staff in being open when things have gone wrong in their care, fear, equity and fairness, and stress and bullying. It is worth recognising that these are challenges staff may get in the way of having open conversations etc. with patients when things have not gone as expected.
* **Clinician’s time constraints** **and pooled lists** - Listening to clinicians during an event on consent, we heard feedback about the numbers of patients on clinic lists for the consent process which they felt did not allow them sufficient time to have adequate consent conversations. At the same event we listened to clinicians raising the issue of **pooled lists**. They expressed concern around patients being consented by clinicians who would not be performing the procedure.
* **Patients with specific capacity issues** including mental health problems, **learning disabilities, dementia etc. How do teams make adjustments so patients** aren’t automatically excluded, are considered able and included to participate in their own safety?
* **Language barriers –** NHS Resolution have dealt with clinical negligence claims which highlight the potential for safety issues arising from misunderstanding between patients and clinicians due to language. One case, Mordel v. Royal Berkshire NHS Foundation Trust[[2]](#footnote-2) concerned a pregnant woman, whose first language was not English was found not to have understand the sonographer’s question around screening for Down’s syndrome. Accordingly, she did not receive screening and the trust were found liable for a substantial claim. Another claim, Nilujan Rajatheepan v. Barking Havering and Redbridge University Hospitals NHS Trust[[3]](#footnote-3) concerned a failure to ensure a mother who spoke very little English understood breast-feeding guidance leading to her baby developing cerebral palsy.
* **Timing challenges in involving harmed patients/families** - Patients and/or families who might be adjusting and/or grieving after being harmed or experiencing a death might not always be ready to be involved with an investigation at the outset. However, they may be able and wish to be involved at a later date.

* **Do we understand how best to engage patients to discuss their proposed care or treatment** –The consultation document notes (p.10) that sincerely asking patients ‘do you have any concerns’ is a good starting point. How far is this evidence based? Has there been research into the most effective questions/methods for engaging patients in conversations about their safety

**Empowering patients to speak up about safety concerns they may have regarding the care they witness being delivered to other patients**.  The delivery of care may not be restricted to that being delivered by clinicians but by family members.

* **Striking a balance between fully informing patients and not sharing information which is unsuitable for sharing** – for example, during an investigation it may not be suitable to share all the information pertaining to the incident with a patient.
1. **Do you agree with the principles of how Patient Safety Partners should be involved in an organisation’s patient safety work?**

Yes, we have no further suggestions.

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

Yes, and note that whoever takes a role as a Patient Safety Partner should be empowered to be impartial.

1. **Does the draft framework provide sufficient guidance to help organisations to introduce Patient Safety Partners in order to support their patient safety work?** Yes.
2. **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?**

We have no comment here and leave this to others.

1. **We estimate organisations may need to invest around £6000 per year in Patient Safety Partner work. Do you agree with this estimate?**

We have no comment here and leave this to others.

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

We have no comment here and leave this to others.

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

Yes. Other elements of training we would suggest are:

* Training for awareness on incident management including procedures for incident reporting, Serious Incident reviews, complaints, legal claims and inquests. This could include awareness of NHS claims and costs of harm.
* Safety II –as per the Patient Strategy, how do you ensure that Patient Safety Partners are familiar with the Safety II[[4]](#footnote-4) approach to patient safety, i.e. learn about what has happened, what did not go as planned but also what worked well, how did the people and systems adapt or work to succeed and how can we replicate this. NHS Resolution’s publication Being Fair[[5]](#footnote-5) recommended this as a way of building a positive learning culture.
* Dealing with senior people - Macmillan Cancer Support provide training for their volunteers (voices training) – enabling people to deal with senior people.
* Training or induction which allows Patient Safety Partners to understand the perspective of different staff within an organisation.

**Roles for Patient Safety Partners**

1. **Do you agree that these are appropriate roles?**

Yes. Other roles for Patient Safety Partners could be promoting the use of patient voice within induction programmes for new staff, and also play a key role in medical educational programmes running within trusts.

1. **Are you aware of/is your organisation taking any additional approaches to involving patients and the public in patient safety work? Please share any examples.**

NHS Resolution have involved patients in their safety and learning work in the following ways:

* Through the national maternity incentive scheme[[6]](#footnote-6) safety action 7[[7]](#footnote-7) NHS Resolution incentivises involving patients in patient safetyby askingtrusts to ensure that they have a mechanism for gathering service user feedback, and that they work with service users through their Maternity Voices Partnership to coproduce local maternity services.
* Patients have been engaged with sharing learning from harm and claims by providing them with a platform to share their experience at training webinars and events for clinicians on issues such as consent and cauda equina syndrome.
* NHS Resolution undertook research with The Behavioural Insights Team into why patients make legal claims[[8]](#footnote-8). The research was designed to hear from patients, but was also developed and designed with support from a patient partner.
* NHS Resolution membership of the oversight Committee meeting for 'Patient and family involvement in serious incident investigations’ using staff to provide insight and support to national level projects to involve patients and families.
* Mediation – NHS Resolution has successfully piloted and now embedded the use of mediation for legal claims and in dealing with practitioner performance concerns. This has provided patients and families with the opportunity to feedback to the trust and ‘air’ their issues. It has also provided reassurance that here has been system change designed to prevent their issue from happening to other patients.
1. **Outside of NHS trusts, some individual sites, branches or practices are part of larger groups or chains of healthcare providers. In your view, should the following types of organisation appoint Patient Safety Partners at each individual branch/site or to support patient safety work across the whole group?**

We have no comment here and leave this to others.

1. **Please use the box below if you have any other comments on our draft Framework for involving patients in patient safety.**
* It is possible that patients attracted to the role of Patient Safety Partner may have had difficult experiences as patients or through their family. It would be worth exploring this with individual Patient Safety Partners at induction and helping them to understand how it might impact them to hear similar stories or e.g. deal with specific areas of medicine or issues. The Framework could include information for NHS providers about ensuring psychological or other support for Patient Safety Partners. Issues which clinicians are routinely exposed to, could be more distressing for lay people.
* If Patient Safety Partners are appointed by one organisation, will there be opportunities for them to support patient safety work across patient journeys that cross all the care sectors? Thinking creatively about the role across the integrated care system has the possibility of increasing the impact of the role.
* Could the Patient Safety Partner role be introduced to Prison services independent providers and Clinical Commissioning Groups?
1. https://resolution.nhs.uk/wp-content/uploads/2019/07/NHS-Resolution\_Being-fair-Website2.pdf [↑](#footnote-ref-1)
2. Page 65 - https://resolution.nhs.uk/wp-content/uploads/2020/07/NHS-Resolution-2019\_20-Annual-report-and-accounts-WEB.pdf [↑](#footnote-ref-2)
3. https://www.bailii.org/ew/cases/EWHC/QB/2018/716.html [↑](#footnote-ref-3)
4. Hollnagel 2013 [↑](#footnote-ref-4)
5. Page 6 - <https://resolution.nhs.uk/wp-content/uploads/2019/07/NHS-Resolution_Being-fair-Website2.pdf> [↑](#footnote-ref-5)
6. https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/maternity-incentive-scheme/ [↑](#footnote-ref-6)
7. https://resolution.nhs.uk/wp-content/uploads/2020/02/Materity-incentive-scheme-year-three-changes-to-safety-actions.pdf [↑](#footnote-ref-7)
8. <https://resolution.nhs.uk/wp-content/uploads/2018/10/Behavioural-insights-into-patient-motivation-to-make-a-claim-for-clinical-negligence.pdf> [↑](#footnote-ref-8)