Framework for involving patients in patient safety

Summary

June 2021

Introduction

The involvement of patients in their care and in the development of safer services are both priorities for the NHS.[1] People now have a greater expectation that they will be involved in their care and in ensuring it is safe.[2] However, progress has not been as fast or universal as we would like and while patients, and those close to them, are willing to help improve patient safety, they are not always sure what they should look out for or what they can do to help.

This Framework for involving patients in patient safety was announced as a key priority in the NHS Patient Safety Strategy published in 2019.[3] It provides guidance on how the NHS can involve people in their own safety as well as improving patient safety in partnership with staff: maximising the things that go right and minimising the things that go wrong for people receiving healthcare. This framework is relevant to all NHS trusts and commissioners and should also be useful to other NHS settings, including primary care and community services, that are considering how they can involve patients in safety. Integrated care systems should consider how they can involve patients and other lay members as part of their safety governance processes as they develop and mature. Where patients, carers and other lay people become involved in improving and leading organisational patient safety, we refer to them as 'Patient Safety Partners'.

The introduction of PSPs may significantly change the way some organisations approach patient involvement. It requires power sharing, a commitment to openness and transparency between staff and patients, as well as good leadership; it must not be tokenistic. For this reason, the framework advocates organisations first assess their 'readiness' to engage PSPs.

Part A: Involving patients in their own safety

Healthcare staff should be supported to encourage patients to be partners in their own healthcare safety. In particular, staff are key to developing patients' confidence in performing patient safety activities. Patients may question how 'qualified' they are to contribute to their own safety and for this reason may choose not to engage. While

[1] Department of Health (2015) *The NHS Constitution for England*. https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england

[2] Holme A (2009) Exploring the role of patients in promoting safety: policy to practice. *Br J Nurs* 18(22): 1392–1395.

[3] https://www.england.nhs.uk/patient-safety/the-nhs-patient-safety-strategy/

involvement should be encouraged, patients should not feel pressured into being involved in their own safety if they are not comfortable or able to do so.

Inequalities affect patients and their safety. It is important to treat people as individuals and not associate everything about a person with their diagnosis, particularly if they have a learning disability or autism. Healthcare staff need to understand that people with a protected characteristic can face inequalities in terms of their care and safety and having more than one protected characteristic may accentuate that inequality.

Approaches to involving patients in their own healthcare and safety can include:

- Encouraging patients to ask questions by:
  - asking them directly if they have any queries about their care
  - providing leaflets, videos and apps to encourage patients to ask questions or raise issues with professionals.
- Individual information-sharing sessions for patients, including proactively involving them in:
  - monitoring their symptoms
  - understanding their medications
  - following up on test results and appointments
  - making choices about their care, where appropriate.
- Information campaigns such as those encouraging people to be vigilant about staff, visitors and patients cleaning their hands.
- Reporting incidents by:
  - raising concerns through complaints systems
  - flagging them to staff or reporting them to the online national reporting system (currently the National Reporting and Learning System, NRLS; to be replaced by the Learn from patient safety events service (LFPSE).
- Individual involvement in incident investigation.

Whatever the approach, there is a need to ensure that:

- individuals have enough information to participate in decision-making about their care; information should be consistently written in plain language without jargon

- communication is effective, which may include the use of structured communication tools,[10] so that individuals both understand the information they are given and feel safe in communicating their needs
- if individuals feel they need more information they are directed to this
- individuals are trained when required in how to be involved in their own safety, eg in self-medication
- individuals are helped or trained to use technology if required
- when individuals need access to wider support networks relating to their condition or another concern, they are directed to these, including local independent advocacy services.

Staff should also recognise when patients may not want to take any responsibility for safety issues and instead trust that they are being provided with competent care. How patients feel about being involved may depend on the nature of their illness or condition.[11]

Part B: Patient safety partner involvement in organisational safety

PSP involvement in organisational safety relates to the role that patients and other lay people can play in supporting and contributing to a healthcare organisation's governance and management processes for patient safety. Roles for PSPs can therefore include:

- membership of safety and quality committees whose responsibilities include the review and analysis of safety data
- involvement in patient safety improvement projects
- working with organisation boards to consider how to improve safety
- involvement in staff patient safety training
- participation in investigation oversight groups.

[10] https://webarchive.nationalarchives.gov.uk/20190501131836/https://improvement.nhs.uk/documents/3345/Much_more_than_words_summary_v2.pdf

[11] Davis R, Murphy MF, Sud A et al (2012) Patient involvement in blood transfusion safety: patients' and healthcare professionals' perspective. *Transfus Med* 22(4): 251–256.

PSPs can act as ‘knowledge brokers’ as they often have the insight of a user of services across different parts of the NHS, or may have experience of avoidable harm and can therefore help inform the development of safety solutions that cross organisational boundaries. They provide a different perspective on patient safety, one that is not influenced by organisational bias or historical systems.

PSPs perform a very different role from that of a governor in a foundation trust or a traditional NHS volunteer; however, individuals working in these roles can also be a PSP.

The benefits of PSP involvement include:

- promoting openness and transparency
- supporting the organisation to consider how processes appear and feel to patients
- helping the organisation know what is important to patients
- helping the organisation identify risk by hearing what feels unsafe to patients
- supporting the prioritisation of risks that need to be addressed and subsequent improvement programmes
- supporting the organisation in developing an action plan following an investigation, particularly so that actions address the needs of patients
- helping the organisation produce patient information that patients understand and can access.

PSPs’ involvement in staff recruitment can support exploration of a candidate’s understanding and commitment to involving patients in their own safety and in the safety governance of the organisation. PSPs can also lead on ensuring candidates have a good understanding of equality and diversity and are committed to ensuring that this is effectively considered in all patient safety activity. PSPs can help with shortlisting candidates and designing interview questions, and can sit on interview panels.

PSPs can encourage patients, families and carers to play an active role in their safety, to report incidents and participate in their investigation to promote learning, and to help design safer systems of care.

PSPs can also constructively question staff about the safety of organisational procedures and systems that impact on patients.

Developing and training PSPs to a national standard, as part of the implementation of the National Patient Safety Syllabus, will provide these individuals with transferable skills that can be used in other providers, commissioners, national or regional organisations. By networking at different levels of the system, PSPs can start to influence both local and national safety policy.

Working in partnership with PSPs is a new way of working for many staff. Staff will need training and support to involve patients effectively both in their own safety and in the safety and governance of the organisation. Training can provide a greater understanding of how patients can be involved in their own safety, and cover skills in partnership working with patients, including being receptive and responsive to patients who are encouraged to speak up. Patient involvement is part of the national patient safety syllabus[12] currently being developed.

Implementation of this framework will take time. Different organisations are in very different places. Some are already delivering over and above what we advocate here, while others will need to carefully plan and work towards these activities. We will work with the wider NHS to understand the pace at which this work can be delivered.

The NHS Patient Safety Strategy includes the ambition for all safety-related clinical governance committees (or equivalents) in NHS organisations to include two PSPs by June 2022, and for them to have received the required training by June 2023.

Principles of patient safety partner involvement

The principles summarised below set the high-level objectives and standards for involving PSPs. These have been developed from those in the Investing in Volunteers Quality Standard,[13] to reflect the distinction between the PSP role and that of the volunteer: they work in partnership with staff to influence and improve the governance and leadership of safety within an NHS organisation.

[12] https://www.hee.nhs.uk/our-work/patient-safety
[13] https://investinginvolunteers.co.uk/

Principles

1. **Commitment to involving PSPs in patient safety:** The organisation should express a commitment to the involvement of PSPs, and promote their recognition throughout the organisation.

2. **Creating a framework to develop and support PSP involvement:** There is no contract of employment between PSPs and the organisation. Instead, the relationship is based on mutually agreed expectations about the role.

3. **Inclusive approaches to attracting PSPs:** The organisation works to involve PSPs who reflect the diversity of the local community.

4. **Developing PSP roles and task profiles:** The organisation develops appropriate roles for PSPs in line with its aims and objectives, which are consistent with this guidance and which are valued by the PSPs in those roles.

5. **Safeguarding PSPs, staff and patients:** The organisation is committed to ensuring that, as far as possible, PSPs are protected from any emotional and financial harm arising from their role.

6. **Recruiting PSPs:** The organisation is committed to using fair, efficient and consistent recruitment procedures for all potential PSPs.

7. **Induction and training for PSPs:** Clear procedures are followed when inducting new PSPs to their role, the organisation and relevant policies.

8. **Supporting PSPs:** The organisation takes account of the varying support needs of PSPs and provides for them.

9. **Valuing and recognising PSP contributions:** The whole organisation is aware PSPs need to be given recognition.

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