Community Pharmacy
Patient Safety Group

Response

NHS Improvement

Developing a patient safety strategy for the NHS

15 February 2019

For enquiries regarding this response please email contact@pharmacysafety.org

About the Community Pharmacy Patient Safety Group (CP PSG)

The Community Pharmacy Patient Safety Group was set up in February 2015 to advance patient safety culture and practice across the community pharmacy sector, including by increasing the reporting of patient safety incidents and enhancing the learning opportunities available when things go wrong. The Group has representation from community pharmacy Medication Safety Officers (MSOs) from the largest pharmacy chains and the independent sector. Most of these individuals are Superintendent Pharmacists, or senior members of their team.

The Group meets bi-monthly to openly share and learn from each other, as well as from other safety-conscious industries. We consider how this learning could be applied and disseminated across the pharmacy network and wider health system, and then work together to create the opportunities to do so.

Every group member, and their employer, has committed to reducing the occurrence of patient safety incidents, sharing good practice and improving the overall approach people take when things go wrong. We have worked on a range of safety topics over the past few years including; introducing common principles for reporting and learning from incidents, understanding the role of community pharmacies in safeguarding vulnerable people, looking at how medication delivery services can be made safer, and disseminating information and resources about serious national risks to pharmacy teams.

Response

In September 2018, we wholeheartedly welcomed the Secretary of State for Health's announcement that a national patient safety strategy would be developed, aligned to the NHS Long Term Plan. We have discussed the proposals for the national strategy laid out in this document and feel that the underlying principles are clear and easy to support. We do however believe the strategy, as currently written, is heavily steered towards secondary/in-hospital care. We feel 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, especially given the clear focus on out-of-hospital care in the NHS Long Term Plan.

We support the underlying principles of the draft patient safety strategy and believe these align closely to the patient safety principles that we have embedded throughout community pharmacy settings over the last few years. More information about the simple 'Report, Learn, Share, Act, Review' principles, which we feel could be applied to all healthcare settings, can be found at https://pharmacysafety.org/principles/.

We welcome the recognition of the value of human factors and ergonomics expertise in improving systems and processes but believe that further research is needed to truly support practitioners throughout the system to reduce the likelihood of making a mistake. For example, pharmacists in every care setting will be acutely aware of the risks of errors involving Look-Alike Sound-Alike (LASA) medicines, yet very little robust research on how to minimise the likelihood of these errors occurring has been commissioned/published. For instance, could we manipulate/interrupt the human brain's Z-track reading style to minimise risks of these errors? How do we take into account fatigue and other human factors?

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 (a just culture, openness and transparency and continuous improvement).

We have however found that many practising healthcare professionals (registered and non-registered staff) do not easily relate to the term 'just culture'. Many community pharmacy organisations instead talk about a safety culture or an open learning culture.

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

Often the understanding of what a just culture means in practice is not clear, or previous experiences and treatment of staff were unjust and can affect an individual's future open reporting and sharing behaviour. Just culture can be quite complex and sometimes subjective, so it is important that all individuals have a good understanding of the simple principles which underpin a just culture. The Royal Pharmaceutical Society describes a just culture as one which promotes openness, transparency and discussion; raising concerns and learning from mistakes.

Some community pharmacy organisations have found the concept of a 'just culture' is often not well understood by practising healthcare professionals and their teams. We have also experienced a lack of acceptance/understanding of just culture by some families and patients who have been affected when a patient safety incident occurs. Due to the enormous emotional distress involved when an incident occurs, families can sometimes be more interested in seeking reprisal or punishment of the individuals involved in making a mistake than in any risk minimisation efforts to prevent a similar mistake happening again.

Removing the risk of punitive action for inadvertent error can often be quite difficult, it is therefore important to involve all relevant individuals within an organisation in understanding what a just culture means in practice. For instance, a just culture should create a working environment which is rewarding to work within, professional empowerment, and enhances the quality of service to patients and patient experience. Sometimes this element of a just culture is forgotten by organisations and the culture is more related to the actions taken once something has gone wrong.

c. Are you aware of A just culture guide?

Yes. We welcomed the just culture guide when published last year. It is a helpful tool to support healthcare professionals and managers in identifying what actions may be appropriate to take as part of an internal investigation. The tool may benefit from worked examples using an incident story, to help professionals and patients understand what would and would not be considered acceptable.

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 – including Board directors and those who work in Human Resources for instance. Learning about culture should be built into training for individuals across different roles in the organisation, so it becomes less subjective to those involved when an incident occurs.

The Centre for Pharmacy Postgraduate Education (CPPE) is developing a patient safety module for community pharmacy professionals on just culture and we feel it would be beneficial for these training programmes to use similar language regardless of care setting, so there is less variance in interpretation of just culture across different organisations.

We have found that it is not always clear to patients and the public what actions are taken within an organisation when a patient safety incident occurs and many patients are not aware of how a just culture impacts the process of investigation within an organisation. 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. The Community Pharmacy Patient Safety Group have published an outline schematic on what happens when an incident is detected in a community pharmacy setting which is available on our website. This is just one part of a much bigger picture however and we feel it would be useful for a clear document, aimed at patients, families, carers and healthcare professionals alike, to be published which outlines the purpose and aim of different types of investigations that can occur when something goes wrong (e.g. the internal patient safety investigation, a coroner's inquest, a criminal investigation). This would support professionals and organisations in carrying out thorough investigations whilst meeting patient and family needs and expectations during these difficult periods for everyone involved.

We also believe it would be very useful for healthcare professionals and organisations to have access to examples or measures of what 'good' and 'great' look like when it comes to just safety culture. Every organisation and team will be at a slightly different stage in their safety journey and it would be valuable for teams to understand how they are doing.

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. There is no competitive element to patient safety, yet NHS trusts are often compared against each other in NRLS outputs or their own internal performance systems. We do not take this approach in community pharmacy and the community pharmacy Medication Safety Officers are instead sharing and learning together, through our bi-monthly network meetings and in-between via email, to help stimulate a whole-system patient safety journey.

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.

Our group also feel that internal incident investigation processes need to run completely separately from any insurance claim/compensation and litigation with the family.

f. How can we further support continuous safety improvement?

Helpful feedback from reporting incidents is fundamental to driving improvement. Some professionals and many patients do not see the value of reporting a patient safety incident if there is no feedback loop once it has been reported.

Continuous safety improvement involves sharing learning and best practice effectively across networks to reduce duplication and unnecessary variation. Improving communication across care settings is crucial to ensure that each part of the system recognises and understands the

strengths and challenges faced by all the healthcare professionals involved in a patient's care, as well as their role and contributions.

2. INSIGHT

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

Yes. We have previously highlighted that too often the NHS patient safety team has sufficient data but insufficient insight to appropriately use it. We hope that the Patient Safety Incident Management System (PSIMS) in development will help improve this situation by ensuring all incident reports are valuable to support learning and risk minimisation. We have also found that many local risk management systems develop and produce insight but this is then not cascaded further to other organisations to spread learning.

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

We welcome the redesign and standardisation of safety alerts proposed in the strategy. We believe that there is a lot of room for improvement with regards to safety alerts and would be pleased to feed into this process. At present there is no structured follow-up mechanism in place to monitor the impact/implementation of an alert and once an alert has been issued it is rarely re-issued or updated. We feel this would be valuable to refresh practitioner knowledge as and when there are trends of incidents re-occurring. Involving those affected (both healthcare professionals and patients) in the development of specific safety alerts could also add value.

Our group have sometimes found medicines recall alerts to be non-patient-centric (e.g. requiring patients to return their medicines and visit their GP when the alert is launched on a Friday). We feel there should be a mechanism in place for practising professionals to feed in learning or suggestions for these alerts as part of the review process.

Distribution lists for safety alerts need to be maintained to ensure the appropriate individuals in every organisation are receiving this vital information to cascade further.

3. INFRASTRUCTURE

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

Yes, we are supportive of the proposals to improve understanding of patient safety across healthcare to create the conditions for patient safety culture to develop further. We believe it is vital that all undergraduate programmes for healthcare professionals embed patient safety throughout learning, rather than teaching this as a standalone or bolt-on module. We believe access to the national curriculum should be widespread to ensure that patient safety is an integral element of the education of any person providing NHS-funded care.

We support the proposals to appoint patient safety advocates and a dedicated patient safety support team. We do however feel this team of experts needs to be easily accessible to all providers of NHS-funded care who may benefit from their expertise, rather than NHS staff alone. Community pharmacy teams/MSOs and other professionals working in primary care are likely to require as much if not more support from this dedicated team, due to the smaller organisational support structures which surround them.

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?

We feel the national patient safety curriculum needs to be enjoyable and engaging. The curriculum should be brought to life with 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 to implementation. Online training can be beneficial as long as there are videos and engaging content. The content must include case studies and examples from many different healthcare settings/incidents/scenarios.

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 working in the environments that everyday healthcare professionals work in, to understand some of 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?

We feel it would be very valuable to involve real patient stories/case studies and families where possible in the training materials (e.g. in videos and/or animations). It would be very beneficial for these materials to describe what an effective resolution looks like in practice and the journey that is often required to get there. Patients speaking first hand about how they want to be treated throughout an investigation would be valuable.

In terms of patient/family involvement more generally in investigations, we feel this is very important but sometimes does not work well due to the timing of their involvement. Very soon after an incident has occurred, the patient/family and healthcare professionals involved will all be distressed and emotive. In order to ensure the most effective involvement of a family in an investigation, this should be when the organisation/professionals involved are able to be most open and honest about what has happened i.e. because they have carried out a thorough investigation into what went wrong and why. This can be particularly important if the police and/or a coroner are involved.

g. Where would patient involvement be most impactful?

If they do not already, we believe it would be valuable to involve patients in the national alert panels or case reviews to help with their understanding of the learning and feedback process that is associated with an effective safety culture.

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

Yes, we support the proposals to appoint a dedicated patient safety support team. We do however feel this team of experts needs to be easily accessible to all providers of NHS-funded care who may benefit from their expertise, rather than NHS staff alone. They also need to be able to link in with existing structures, organisations and companies where required. Community pharmacy teams/MSOs and other professionals working in primary care are likely to require as much if not more support from this dedicated team, due to the smaller organisational support structures which often surround them.

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 safety initiatives and would like to be closely involved as these initiatives are agreed and designed. We are already contributing to the Medicines Safety Programme and would like to ensure all NHS-led safety improvement workstreams are as joined up as possible to have the greatest impact on patient care. The Community Pharmacy Patient Safety Group should in particular be closely involved as the final interventions and priorities for the work aligned to the Medication Without Harm challenge are decided.

We also support the proposals to embed a more structured approach to the Patient Safety Collaboratives programme as we have found there to be significant variation in approach and outputs from the Collaboratives. We have found that many Collaboratives are unaware of the key role that community pharmacies play in patient safety, in particular medicines safety.

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?

Community pharmacy MSOs have found it to be most effective when national patient safety alerts/directives give clear and defined expectations for different groups of healthcare professionals to support consistent interpretation and implementation of any improvement methodology.

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

We have found open discussion of serious risks, to help draw out best practice, amongst networks of MSOs to be a very effective way of driving consistent improvement and reducing risks across the community pharmacy sector. 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 regions or nationally.

e. How should we achieve sustainability and define success?

In order to truly drive improvement and ensure sustainability, it is without doubt that funding must be committed to patient safety improvement in a consistent way. The community pharmacy Quality Payment Scheme has allowed pharmacy teams at varying stages on their safety journey to narrow their focus to the most significant risks and drive reporting and learning cultures at a local level.