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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?

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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:
The Royal College of Radiologists

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:

Proposed aims and principles

6 Do you agree with these aims and principles?

Yes

Please explain your answer:

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

Please provide details:
• Time pressures and IT infrastructure problems
• Increasing clinical demand in the context of significant vacancy rates
• Central (government) treatment targets

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

No

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

Please provide details:
Emphasise human factors training

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

Please provide details:
Willingness to learn, no blame culture, patient safety being pivotal to patient care

11 How can we further support continuous safety improvement?

Please provide details:

Insight

12 Do you agree with these proposals?

Yes

Please explain your answer:

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

Please tell us if you have any suggestions:
There are significant issues with reporting as it currently stands. The biggest problem is with the IT infrastructure used for reporting - there have been numerous discussions of just how bad DATIX is, but little appears to change. The technical problems with DATIX act as a clear barrier to incident reporting, mainly because of the time barrier. Local contextualisation to DATIX allows granularity of information / causes to be lost / underemphasised.

-DATIX is also poorly matched to report some of the systemic failures we face: for example, persistent IT problems and persistent staff shortages. These are a clear cause of risk, but don't fit neatly into a reporting model.

-NHSI should think about reducing the burden for reporting (ideally a guarantee that one could log a DATIX form in < 1 minute), and also think about how we report systemic problems with infrastructure in a way that joins into the DATIX system.

-Strategy to deal with the blame culture, or at least a statement regarding their stance on it. If looking to base ourselves on aviation system, have to not be scared to state a potential or actual mistake (although hard following the junior doctor incident last year).

Infrastructure

14 Do you agree with these proposals?

Yes

Please explain your answer:
Safety is a Generic Professional Capability and as far as our curriculum is concerned, it is how we incorporate it.

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

Please tell us if you have any other suggestions:
Apart from the important points about the need for pro-active approaches to patient safety and the importance of human factors/ergonomics, the whole document seems still very much stuck in the “Safety 1” mentality - look at what went wrong, try to fix things retrospectively by working out where the weak link was and improvement involves a new policy or more training for people to follow procedure better in future. And this then sits at odds with the stated aims of a just culture, more openness and transparency etc. It would be a better strategy if it were able to embrace an overall “Safety 2” approach. The negative, chastising language in the consultation document needs to be looked at again.

The default position should be that staff do already care about patient safety, not from a position that they are deficient in this aspect. This document implies that staff are getting it wrong, and its answer is that they need to be “given” skills. Staff are the key, and that they can BE the patient safety infrastructure, but only if they are genuinely given the opportunity to do so. In fact, staff are already constantly adapting and responding to local or individual complexities to get it right as much of the time as possible.

In some ways, this is especially embedded in Clinical Oncology, which is constantly striving to improve treatments based on the best available evidence. However, more work is needed re: the practicalities of complex interactions with hospitals and treatment doesn’t work well - and a greater patient safety perspective embedded would be useful.

-There are concerns about whether a “curriculum” is the way to do it, unless it’s very much focused on the need for curiosity about every aspect of care, a real exploration of a just culture (which goes so much wider than the NHS “Just Culture Guide”), psychological safety and well functioning teams. The cadre of “patient safety specialists” implies another layer of bureaucracy, which can give rise to scepticism. If on the other hand, this was a specialised cohort of people who had had human factors / ergonomics / systems approaches’ training and expertise to be on hand to advise NHS organisations then this might indeed be useful.

There could be a strong argument made from oncology about the involvement of patients and families as a means to improve safety. They are often the ones who notice that something isn’t as it should be, but perhaps don’t feel able to speak up with the power imbalance that exists between themselves and healthcare professionals (especially doctors). Witness all the work around PROMs where enabling a patient voice has improved safety and therefore survival.

There are concerns about the implementation of a patient safety curriculum. It is not clear from either the consultation document or the draft curriculum who would be expected to follow the curriculum and at what stage of training (e.g. would it be covered by doctors during foundation training or would we be expected to incorporate it into specialty training?). There is no information about how it is expected that the curriculum will be delivered, who will oversee delivery or be responsible for it at a local level, or how it will be assessed.

While nothing in the curriculum itself is controversial, the lack of information about its intended use makes it difficult to say that we would/would not support it or to see what benefits would be gained from it.

If we are expected to incorporate the patient safety curriculum into our specialty curricula, this would be problematic for Clinical Radiology (CR) in particular as we are already at an advanced stage in the rewrite of this curriculum and due to submit to the GMC at the start of July.

There is also a draft QI curriculum in circulation from Academy of Medical Royal Colleges, who have asked colleges to comment on how they intend to incorporate this into their specialty curricula.

The draft patient safety curriculum and QI curriculum together are as long as our draft CR curriculum. Part of the intention behind the new GMC requirements for curricula is to make them more concise so any expectation to add more into our document would be challenging.

If the intention is for the patient safety curriculum to remain separate and for trainees to be asked follow this and sign off its competencies in addition to doing so for their specialty training curriculum, then this is likely to be very unpopular.

Ultimately, patient safety and QI are both part of specialty training anyway, so what additional benefit would be gained from a separate patient safety curriculum is unclear.

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

Human factors and ergonomics, Patient/family/carer engagement, Risk management, Quality improvement science, Change management

Please provide details of any other areas:
In the CO curriculum, all of the above mentioned will have probably been already visited in FY and CT training. What we have to take to the next level are human factors, patient / family engagement and communication skills and then investigation, thinking QI science and change management.

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

Human factors and ergonomics, Patient/family/carer engagement, Risk management, Quality improvement science, Change management

Please provide details of any others:

18 How senior should patient safety specialists be?

Minimum Band 8d

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

Please provide details:
As a specialist trainee patients will be involved in this level of training as the experiences will come from the real experience. In reviewing and resolving issues, trainees and trainers could include patients

20 Where would patient involvement be most impactful?

Patient to clinician (1:1) level, Clinical pathway design and management level

Please provide details of any other areas:

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

Yes

Please explain your answer:
Advice and top up training could be centrally delivered in Trusts allowing cross fertilisation across clinical groups.

Initatives

22 Do you agree with these proposals?

Yes

Please explain your answer:

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.

National improvement collaborative, Regional improvement collaboratives, Communities of practice

Please tell us of any others:

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

Demonstrating evidence of impact and value, Organisational/peer-to-peer sharing, A national or regional spread programme

Please provide details of any others:

26 How should we achieve sustainability and define success?

Please provide details:

-Sustainability – by demonstrating impact on patient safety and improved workplace culture, the measures should be self sustaining

-Success - trend in reporting incidents shifts from harm to near miss, less litigation