

Healthwatch Worcestershire response to Developing a Patient Safety Strategy for the NHS Consultation

Proposed aims and principles

6 Do you agree with these aims and principles? Yes

Please explain your answer:

The NHS need to embrace continuous improvement to improve outcomes for patients - this requires a no blame culture, although individuals must still be held to account for their own behaviours/attitudes.

The no blame culture needs to extend to patients who must feel free to comment on their treatment without fear that to do so will have a negative impact on future treatment - statement based on reported patient experience.

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

Please provide details: Focus on performance targets, and risk of liability.

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

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

Please provide details:

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

Please provide details:

11 How can we further support continuous safety improvement?

Please provide details:

Involve patients and public through co-production.

Engage patients champion in effecting culture change.

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:

Infrastructure

14 Do you agree with these proposals?

Yes

Please explain your answer:

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

Please tell us if you have any other suggestions:

Involve patients and the public in training

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

Patient/family/carer engagement, Risk management, Change management, Communication skills, The components of a patient safety culture

Please provide details of any other areas:

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

Patient/family/carer engagement, Quality improvement science, delivering education and training, Change management, The components of a patient safety culture

Please provide details of any others:

18 How senior should patient safety specialists be?

Executive level (Executive Senior Manager)

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

Please provide details:

Consider filling posts from outside NHS by those with transferable skills.

20 Where would patient involvement be most impactful?

Patient to clinician (1:1) level

Please provide details of any other areas:

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

Not Answered

Please explain your answer:

Initiatives

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:

Practice effective shared decision making with patients

Raising patient's awareness of their rights and what a safe service looks like by providing information e.g. how the risk of sepsis will be managed.

provide information about diagnosis and future care.

24 What are the most effective quality improvement approaches or delivery models? Select your top three answers only.

Programmes based on improvement capability and culture, Communities of practice, Lean approach

Please tell us of any others:

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

Use of champions, Local adaptation of processes/approaches, Organisational/peer-to-peer sharing

Please provide details of any others:

26 How should we achieve sustainability and define success?

Please provide details: