Patient Safety Syllabus consultation: response from the Parliamentary and Health Service Ombudsman

28 February 2020

1. Introduction

1.1 We were set up by Parliament to provide an independent complaint handling service. We make final decisions on complaints that have not been resolved by the NHS in England and UK government departments and other public organisations. We look into complaints where someone believes there has been injustice or hardship because an organisation has not acted properly or has given a poor service and not put things right.

1.2 We share findings from our casework to help Parliament scrutinise public service providers. We also share our findings more widely to help drive improvements in public services and complaint handling.

1.3 We welcome the opportunity to provide feedback on the draft National Patient Safety Syllabus, which will provide a common framework for the patient safety education and training of NHS staff.

1.4 Our response draws on learning from our complaints and engagement with partners in the NHS. The majority of complaints we receive are about the NHS in England and many of these complaints relate to patient safety issues and/or investigations. Our casework is a valuable source of insight to support NHS organisations and staff to learn from when things go wrong.

2. Our response to the draft National Patient Safety Syllabus

2.1 We welcome the new syllabus in setting out a single shared approach to improving the skills and knowledge that are necessary for patient safety across the NHS. The syllabus rightly recognises that patient safety is everybody's business – a shared responsibility for everyone working in the NHS, irrespective of their role or seniority.

2.2 We know from our casework that a culture of learning is essential in driving improvement in patient safety. We are pleased to see that the importance of a learning culture is woven throughout the syllabus in every domain.

2.3 We support the syllabus' commitment to a just culture where staff feel confident to speak up and identify what went wrong. Whatever the cause, whether it be human error or systems failure, staff and organisations can and must take action to reduce the chances that the same thing will happen again.

2.4 The syllabus highlights the value of leadership skills in improving patient safety. Insights from our work have shown that compassionate and inclusive leaders who value feedback and learning from serious incidents and complaints are essential in driving improvement in the quality of care.

2.5 We are pleased to see the strong emphasis that has been placed on learning from incidents and providing staff with the appropriate skills to carry out effective patient safety investigations.

2.6 The syllabus expects staff to have knowledge of national learning reports and to be able to use these findings. We regularly publish reports to share learning from our casework and are working to start publishing our decisions from 2021. Our insight reports and casework provide valuable learning that NHS staff can use to drive improvements in patient safety.

2.7 While we welcome the syllabus, we have also identified a number of ways in which the syllabus could be strengthened.

2.8 We are disappointed that the syllabus does not incorporate learning from complaints. We recommended in our response to the Patient Safety Strategy consultation last year that a national patient safety curriculum should cover the complaints system and complaints process.

2.9 Complaints are vital sources of insight to help improve care quality and safety. Staff of all professional groups – clinical and non-clinical – have a crucially important role to play in this process. Our research (due for publication in March 2020) has found that staff can lack confidence in their skills to handle complaints effectively and ensure the learning from complaints translates into concrete action to improve quality and safety. A recent study by Healthwatch made similar findings.

2.10 Our work has identified the need to consider complaints processes alongside other responses to patient safety incidents. We want all staff to be able to choose the most appropriate response to patient safety incidents – whether this be an incident investigation, complaint process, and/or claims-process – and to be able to effectively engage in each process. This will require effective leadership and governance arrangements.

2.11 For example, the syllabus would benefit from a greater focus on providing staff with the skills and knowledge they need in the event that a claim is pursued, including awareness of the role of NHS resolution.

2.12 We welcome the recognition of the value of including patients and carers in patient safety investigations. This part of the syllabus should include the competencies needed by NHS staff to effectively engage with parents and

carers. For example, by developing a positive feedback culture, patients and carers can feel empowered to discuss their views and experiences in an open and responsive environment that values feedback as a source of learning and improvement. Patient advocacy organisations also play a crucial role in this area.

2.13 Over the past year we have been developing our Complaints Standards Framework for the NHS in partnership with the Health and Social Care Regulators Forum and patient advocacy organisations. This will provide a single, shared set of standards for NHS staff to follow when handling concerns and complaints, as well as how we expect managers and leaders to capture learning to improve their service. Given the role of complaints in informing improvements in patient safety, the National Patient Safety Syllabus should reference the Complaints Standards Framework and ensure it is consistent with the principles of the framework.

2.14 Whilst it is too soon to provide descriptions of competencies in relation to complaint handling, the Complaints Standards Framework will set out 4 core principles of an effective complaints system:

- Promotes and demonstrates a learning and improvement culture
- Goes out of its way to seek feedback
- Is thorough and fair
- Gives a balanced and open view

2.15 The Complaints Standards Framework is the first step in professionalising the role of complaint handling in the NHS. We will be publishing guidance on how NHS staff can embed these principles in their day-to-day work and this will be used to design future training modules and accreditation.

2.16 Finally, as the syllabus is intended to cover the whole system, it is important to ensure it is accessible to everyone who works in NHS services, as well as patients and carers. Using plain English and avoiding or explaining technical terms (such as ‘Failure Mode’ or ‘Hierarchical Task Analysis’) more fully would improve the accessibility and usability of the syllabus.

3. Next Steps

3.1 PHSO would be happy to work with the Academy of Royal Medical Colleges and Health Education England to ensure the next iterations of the syllabus properly reflects the role of complaints in driving improvements in patients safety and reflects the principles of the Complaints Standards Framework and the resulting training development. We look forward to meeting in early March to discuss how best to achieve this.