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A formative evaluation

The patient safety specialist role

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Between September 2022 and March 2024, THIS Institute conducted a formative evaluation of a new role in the NHS in England: the patient safety specialist. We spoke with people involved in developing and supporting the role and examined the perspectives of role holders using a survey, focus groups and case-study interviews.

Who are the current role holders?

Our national survey of patient safety specialists provided a snapshot of the current profile of role holders and their experiences of the role to date.

Most respondents (68%) came from a clinical background; half (48%) were registered nurses and 8% had a medical background. Three quarters (74%) were female and the majority (88%) identified as white.

Immediately prior to becoming patient safety specialists, about half had a role with 'safety' in the job title.

Our statistical analyses did not expose strong associations between the backgrounds of specialists and their experiences or self-reported impact in the role.

Seniority and pay

The majority of patient safety specialists responding to our survey (79%) were employed within Band 8, with just over a quarter in Band 8a.

What we did

- Interviews with NHS England's patient safety team
- Survey of 184 patient safety specialists
- Six focus groups with 32 patient safety specialists
- Interviews with 26 patient safety specialists and their colleagues
- Two workshops with 29 patient safety specialists
- Observations at national, regional and local meetings

Want to find out more?

Visit the project's webpage (https://www.thisinstitute.cam.ac.uk/research/projects/the-patient-safety-specialist-role/) or email us to receive updates about the study's findings and related publications (pss@thisinstitute.cam.ac.uk).

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Participants in interviews, focus groups and the survey agreed that role holders should be relatively senior but also recognised that appointments at the lower end of Band 8 made it possible in some organisations to perform the role full time or with a high proportion of FTE.

Our focus group and interview data suggest that, on balance, participants felt that it was more important for patient safety specialists to have more time to do the job well than to appoint at higher grades. At the same time, higher grades usually enabled a greater and more direct access to the board, which participants also saw as pivotal.

The numbers of patient safety specialists employed by organisations varied substantially. Thirty-seven per cent of respondents said that they were the only patient safety specialist in their organisation, 26% said they were one of two, and 37% were employed in organisations with three or more patient safety specialists.

Time

Our findings suggested that many organisations were struggling to resource their patient safety specialists to the extent that specialists themselves would like and that NHS England recommended.

Over a third of survey respondents (38%) had no formally allocated time for their patient safety specialist role, leading many to perceive it as an 'add-on' to their 'day job'.

Over a fifth of survey respondents (22%) were their organisation's only patient safety specialist and had four days per week or less of their time formally allocated to the role; one in 10 (11%) were their organisation's only specialist and had one day or less per week allocated to the role.

In interviews and focus groups, patient safety specialists emphasised the scope of the role, and the need for protected time for it. There were differing views, however, on the pros and cons of splitting the responsibility across more than one specialist in an organisation. Interviews also revealed different approaches to dividing the role: across levels of seniority, professional backgrounds or organisational divisions.

Organisations should carefully weigh up the advantages and disadvantages of different approaches.

Views on the potential of the role

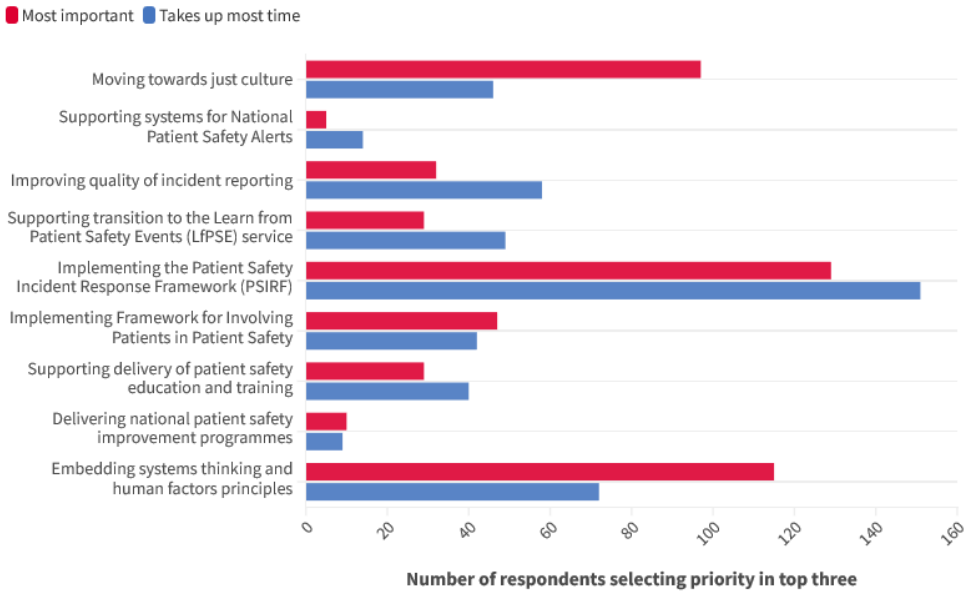
Survey respondents were generally optimistic about the role. Most (58%) felt confident that they could make a positive difference to patient safety; over three quarters (79%) thought that most of the things they did would have a useful impact on patient safety; and over three quarters (77%) believed that the role effectively utilised their expertise and experience.

There were more mixed views on respondents' experiences with their organisations. While 42% felt well supported by their organisation in their role, 30% did not. Only a quarter (24%) thought that their organisation allocated sufficient time to patient safety specialists and only a third (34%) believed that the objectives set by their organisations for the role were appropriate.

Analysis of data from interviews and focus groups suggested that having a clear link to a board member invested in patient safety was crucial to patient safety specialists' sense of being supported, and to ensuring that their work was prioritised appropriately. Interview and focus group data also highlighted the need for accessible training to enable specialists to build their expertise and pass it on to their colleagues.

Patient Safety Strategy priorities

Our survey asked respondents to select three priorities from the Patient Safety Strategy they saw as most important to the role and three priorities they spent most time on. We found some contrast in respondents' selections.



What might be considered as the most strategic aspects of the role – embedding systems thinking and human factors principles, and moving towards just culture – were among the three priorities seen as most important for the majority of respondents. But only a minority of respondents said that these strategic aspects were among the three priorities they spent most time on.

In the survey, focus groups and interviews, participants highlighted how difficult it was for them to prioritise strategic work amid operational pressures, which often had to take precedence. At the same time, participants noted that maintaining a link to the sharp end was crucial in informing their roles.

Organisations should consider carefully what they prioritise in the work of patient safety specialists, ensuring that their focus on maintaining and improving patient safety isn't compromised by operational pressures, and that they have space to lead thinking on patient safety – not just implement safety-related measures.

Navigating contrasting understandings of patient safety

One of the most frequently described challenges, especially in focus groups but also in interviews and the survey, was the need to navigate different ways of doing and thinking about patient safety, reflecting the distinction between Safety-I (focused on finding and fixing problems individually) and Safety-II (focused on resilience, adaptability and learning and improvement across systems).

Participants explained how they continued to encounter what some saw as the 'old way' of thinking, which privileged assurance over learning. Some participants felt that they spent too much time on assurance and what some referred to as 'paper-based' safety. They would have welcomed greater freedom to focus on improvement, but acknowledged that this was not solely within the power of their organisations.

Organisations should consider the balance of their work between assurance and improvement, and seek to make space for patient safety specialists to draw on their growing expertise to lead thinking and introduce new ideas to advance patient safety.

Relationships and culture

In the interviews and focus groups, participants noted that, for patient safety specialists to be successful, they needed to act as 'critical friends', able to 'hold a mirror up' to the organisation while building relationships.

Relationships between providers and ICBs varied across our sites, which also shaped how the specialist role functioned in practice. While for some specialists there was a progressive, collaborative relationship within their systems, for others the provider–ICB relationship continued to feel like one of accountability and performance management.

Not all parts of the regulatory system seemed equally on board with developments in patient safety (for example, those fostered by the Patient Safety Incident Response Framework, or PSIRF) of the kind they were trying to encourage. Specialists saw an important role for national leaders to try to achieve a shift in approach across the whole system.

Conclusion

Our evaluation provided good insight into the challenges, opportunities, highlights and low points of the patient safety specialist role. Participants saw the introduction of the role as a positive and important development. It was evident that the role was something that role holders had to 'grow into'. Participants had had variable success in developing the role, and their organisations' understanding of it, and for most of them finding the optimal approach was still a work in progress.

Whether the role holders had expected it or not, becoming a patient safety specialist turned out to be a significant undertaking. Participants recognised that doing the role justice required resourcing as well as skills and expertise, and that achieving the role's objectives was likely to take more time than might have been originally envisaged.

This initial evaluation is designed to inform a fuller, longer-term evaluation of the role, its impact on patient safety, and how best to support patient safety specialists.

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