Witness Name: Dr Rosie Benneyworth
Statement No.: WITN7689012
Exhibits:
Dated: 19 March 2024

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF DR ROSIE BENNEYWORTH ON BEHALF OF THE HEALTHCARE SAFETY INVESTIGATION BRANCH

I provide this statement in response to a request under Rule 9(1) and (2) of the Inquiry Rules 2006 dated 5 March 2024.

I, Rosie Benneyworth, will say as follows: -

Safety Management System

On 23 June 2023 you provided the Inquiry with a statement (WITN7689001) in which you described work that the Healthcare Safety Investigation Branch (HSIB) is doing towards the implementation of Safety Management Systems in health and care. The Inquiry understands that this work has been continuing. For example, it was referred to by the Patient Safety Commissioner Dr Henrietta Hughes in written evidence to the Health and Social Care Committee's Independent Expert Panel.

Please provide an update on your work towards a safety management system, including next steps.

Safety Management Systems

Introduction

The healthcare system acknowledges the necessity to safeguard patients from harm, yet persistent safety incidents persist. The Health Services Safety Investigation Branch is continuing our work in exploring how a Safety Management System (SMS) approach may be applicable to healthcare.

An SMS is a proactive, integrated approach to safety. It sets out the necessary organisational structures and accountability and will be continuously improved. It encompasses four key areas: safety policy, safety risk management, safety assurance, and safety promotion.

The purpose of an SMS is to ensure that an industry achieves its business and operational objectives in a safe way and complies with the safety obligations that apply to it. However, it is not just a paper-based or electronic system specifically developed for demonstrating compliance with regulatory frameworks. Instead, an SMS should be a dynamic set of arrangements which grows in maturity and develops as the industry evolves.

Investigation 1 – Safety Management Systems: An introduction for healthcare
Our first report, published in October 2023, was an introduction to the concept of SMS. It explored how other high reliability industries, such as aviation, rail, oil and gas, nuclear and maritime, have used the SMS approach in practice. It is notable that SMSs are a regulatory requirement in these industries where safety is critical, with the exception of healthcare.

Our investigation identified three key areas for enhancing safety management in healthcare:

1. SMS Development: Healthcare lacks mandated SMSs, leading to inconsistencies in safety activities. Standardisation and coordination across organisations are needed, along with a shared understanding of safety principles.
2. Safety Accountability: Clarity in accountability is crucial for effective safety management. While existing regulations outline provider-level accountabilities, a multi-level framework is absent, leading to gaps in oversight.
3. Safety Maturity Assessment: Current maturity frameworks in healthcare lack alignment with SMS principles. Future work should assess the applicability of SMS in healthcare, mapping existing safety activities, and establishing accountability frameworks.

Investigation 2 – Safety Management Systems: Accountabilities across organisational boundaries
The second investigation is scheduled to be published in October 2024. It will report on pathways of care for the health needs of patients that require multiple contacts across different healthcare settings and providers. Contacts with the healthcare system will be mapped with a detailed account of organisational patient safety accountabilities. We will explore recurring risks when patients receive care from multiple services, and we will consider vulnerable patients.

Everyone working in healthcare has some measure of responsibility for patient safety. When an organisation is accountable for patient safety, they should ensure that systems and processes are in place to effectively manage safety. This includes healthcare providers and integrated care systems (ICSs).

ICSs bring together providers and commissioners of NHS services across a geographical area to plan care in order to meet the needs of people. An ICS aims to join up hospital and community-based services, physical and mental health, and health and social care to improve long-term outcomes and minimise inequalities. Many patient safety risks go beyond organisational boundaries and may not be managed effectively without a clear safety management process. Gaps in responsibility and accountability can have serious consequences for patient safety.

Investigation 3 – Safety Management Systems: Involving patients and staff
This investigation is scheduled to be published in April 2025. It will begin on conclusion of the second investigation. We will consider how NHS staff and patients could be involved in any integrated SMS approach. We will gain a better understanding of the pressures and difficulties that NHS staff face when performing safety management activities within and across an ICS. This will help us determine if SMS principles could be used to improve safety management. Patients and their carers need to be able to voice safety concerns and this might require coordination across multiple healthcare providers to ensure that these concerns are acted upon.

In conclusion, there's a pressing need to explore and potentially implement SMS principles in healthcare to enhance patient safety. This entails aligning safety activities, establishing clear accountabilities, and assessing safety maturity. Future endeavours should focus on bridging gaps and ensuring effective implementation of SMSs in healthcare settings.

Statement of Truth

I believe that the facts stated in this witness statement are true.

Signed GRO-C

Dated 19 March 2024