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An Overview of
The NHS Patient Safety Strategy

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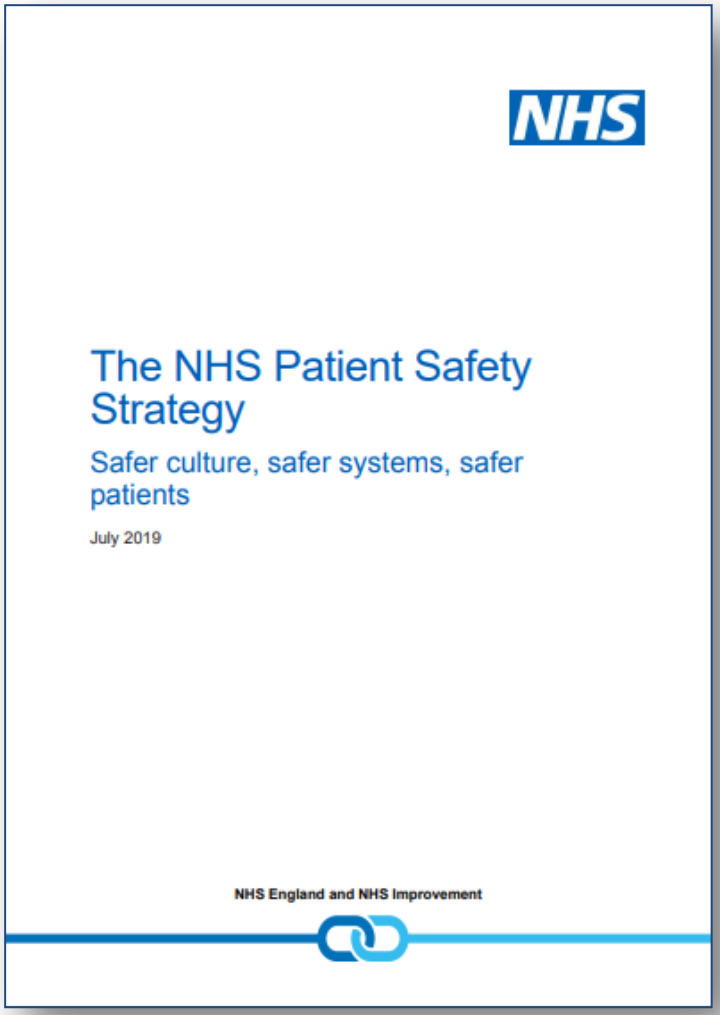

- Launched July 2019
- 527 contributions, stakeholder meetings, engagement events
- Strap line – Safer culture, safer systems, safer patients
- ***'to make progress, we must significantly improve the way we learn, treat staff and involve patients'***

Key Messages

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- “A step in helping us make the NHS ever safer….we will need to adapt over time”
- Patient Safety is not an absolute concept – it responds to patient need and system priorities
- “Golden Thread” running through healthcare
- There is no target to achieve but we should focus on areas of most harm
- Safety, alongside effectiveness and patient experience, is integral to healthcare quality
- Recognises that we operate in complex systems (volume, design, policy, behavior)
- Culture cannot be mandated by strategy but its role cannot be ignored
- Describes the next 5-10 years – sits alongside the NHS Long Term Plan

What's not included

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- Targets – potential to save around 11,000 lives per year but strategy calculates modest gains by 2023/24 of circa 1,000 lives saved and £100 million in treatment costs
- Not prescriptive – rather a collective statement of intent
- Assumption that detail around required actions will come later
- Does not mandate workforce levels or specifically address shortages (covered in The Interim NHS People Plan) but recognises the link between capacity and safety
- Does not address the behaviour of regulators (specifically NHSE/I) working together / stream lining / understanding the new landscapes
- Recognises need to engage primary care and care homes without giving detail

The NHS Patient Safety Strategy

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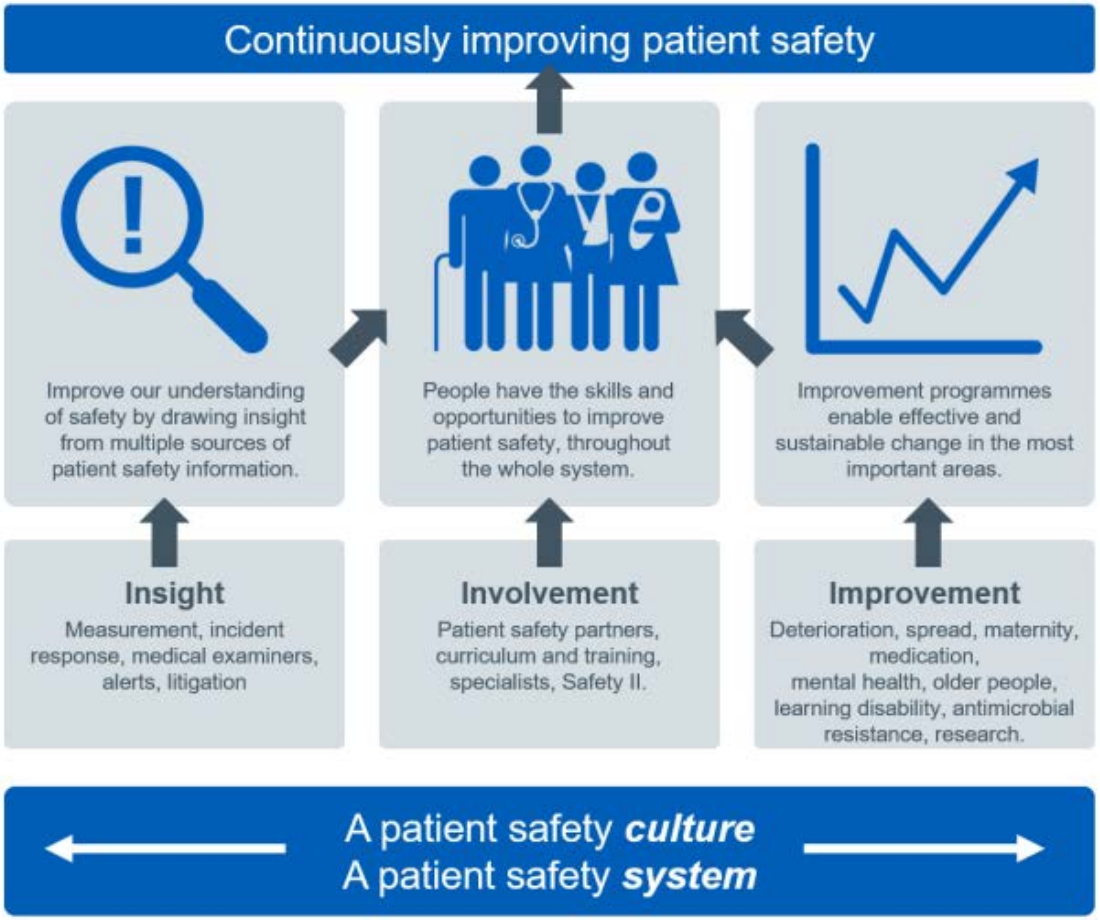
- The **safety vision** of the NHS is **to continuously improve patient safety**

- The NHS will build on **two foundations**
  1. A patient safety culture
  2. A patient safety system

- This development will be supported by **three strategic aims**:



Features of a Patient Safety Culture

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Blame – Just Culture

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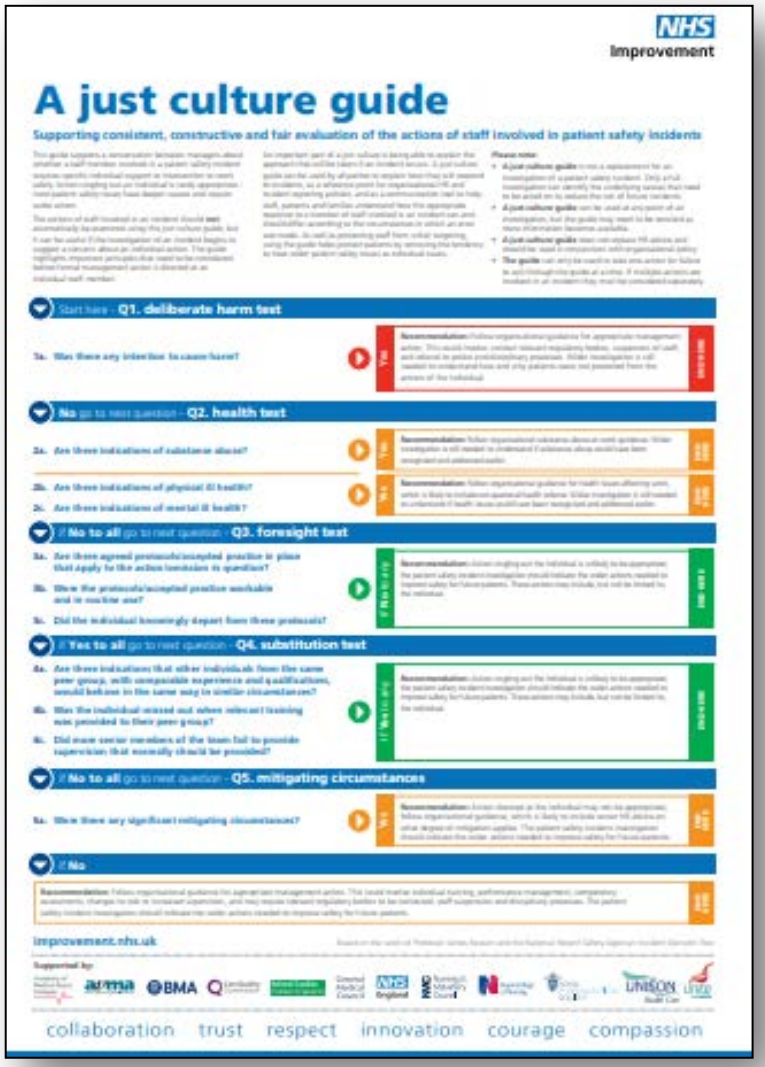
- Fear is too prevalent across NHS staff – patient safety incidents
- Blame is a natural and easy response to error – relies on two myths
  - **Myth of perfection** – if we try hard we won't make errors
  - **Myth of punishment** – if we punish people they will not repeat the error
- Often results in individuals being targeted through 'training' & 'reflection'



NHS Improvement

A just culture guide

Supporting consistent, constructive and fair evaluation of the actions of staff involved in patient safety incidents

Start here - Q1. deliberate harm test

1a. Was there any intention to cause harm?

No go to next question - Q2. health test

2a. Are there indications of substance abuse?

2b. Are there indications of physical ill health?

2c. Are there indications of mental ill health?

If No to all go to next question - Q3. foresight test

3a. Are there agreed protocols/accepted practice in place that apply to the action/omission in question?

3b. Were the protocols/accepted practice workable and in routine use?

3c. Did the individual knowingly depart from these protocols?

If Yes to all go to next question - Q4. substitution test

4a. Are there indications that other individuals from the same peer group, with comparable experience and qualifications, would behave in the same way in similar circumstances?

4b. Was the individual trained out where relevant training was provided to their peer group?

4c. Did more senior members of the team fail to provide supervision that normally should be provided?

If No to all go to next question - Q5. mitigating circumstances

5a. Were there any significant mitigating circumstances?

If No

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collaboration trust respect innovation courage compassion

Safety Systems

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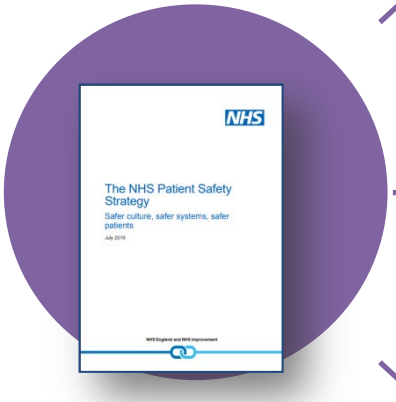

INSIGHT

- Safety measurement
- **Replacing NRLS**
- **PSIRF**
- **Medical Examiners**
- NPSA Committee
- Negligence claims

INVOLVE-MENT

- **Patient Safety partners**
- **Education/Training**
- **Patient Safety Specialists**
- Safety I – Safety II

IMPROVE-MENT

- **National Patient Safety Improvement Programme**

Insight

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- NRLS/StEIS – PSIMS (Patient Safety Incident Management System)
  - use of data-cleansing algorithms and machine learning tools to process the data to provide better and more timely insights
  - priority to make access to data and learning resources easier
  - encouraging local systems to share more of their own safety insights to help diffuse ideas
  - make safety data more accessible and transparent by offering a self-service portal to search, analyse and download data to support local learning
- Implications for the CCG
- Improved ability to search and theme events locally and nationally with a wider range of feedback
- WHCCG contributed to the consultation/workshops around DPSIMS
- CCG has already rolled out DATIX which is mapped to NRLS to support GP reporting but this system may need a major overhaul or replacement

Insight

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The Patient Safety Incident Response Framework (PSIRF): aims to assist learning and improvement; allow organisations to examine incidents openly without fear of inappropriate sanction, support those affected and improve services.

The PSIRF proposals explore:

- **A broader scope**: describing principles, systems, processes, skills and behaviours for incident management as part of a broader system approach
- **Transparency and support for those affected**: setting expectations for informing, involving and supporting patients, families, carers and staff
- **Risk-based approach**: use of proportionate and effective learning responses to incidents, based on the opportunity for learning; ensuring that providers allocate sufficient local resources to implement improvements that address investigation findings
- **Purpose**: insulating it against scope creep and inappropriate use, so that safety investigations are no longer asked to judge 'avoidability', predictability, liability, fitness to practise or cause of death

Insight

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- **Governance and oversight**: different approach to oversight and assurance by commissioners, emphasis on the role of provider boards and leaders in overseeing individual investigations
- **Terminology**: making references to 'systems-based patient safety investigation', not 'root cause analysis', to reflect the 'systems' approach to safety'
- **Timeframes**: adopting timeframes based on an investigation management plan that is agreed where possible with those affected
- **Investigation standards and templates**: introducing national standards and standard templates
- **Investigator time and expertise**: requiring investigations to be led by those with safety investigation training and expertise, and with dedicated time and resource to complete the work
- **Cross-setting investigation and regionally commissioned investigation**: co-ordination of investigation across multiple settings supported with a clearer role for NHS regional teams

Insight

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- Implications for the CCG
- Huge opportunity to target learning and address system issues
- Greater flexibility around timeframes
- New framework publication has been delayed whilst early adopter sites pilot
- Greater focus on provider resolution for patients / family members
- CCG will need to support the development of local investigation strategy's around what gets investigated as an incident – preferably at system (ICS/ICP) rather than organisational level
- Will lead to greater demands for whole system investigations and resource from the CCG
- Opportunity to create a central resource for system investigation to ensure expertise and objectivity (modelled on HSIB)

Insight

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- **Medical Examiner System** aims to:
  - provide a better service for the bereaved and an opportunity for them to raise concerns about care with a doctor not involved in that care
  - enhance patient safety by ensuring that all deaths are scrutinised by an independent medical examiner
  - ensure the appropriate direction of deaths to the coroner
  - improve the quality of death certification
- Acute trust establishing role during 2019/20
- 2020/21 expansion to encompass all deaths, including those occurring in the community and in independent providers (primary care from March 2021)
- Non statutory initially but legislation by March 2021
- Implications for the CCG
- Ability to link current learning from Deaths to Medical Examiner system to drive system improvement
- Resource implication – 1FTE per 3,000 deaths, likely 1-3 Consultant PA's, Medical Examiners Officers drawn from range of clinical backgrounds
- Support implementing in community and primary care

Involvement

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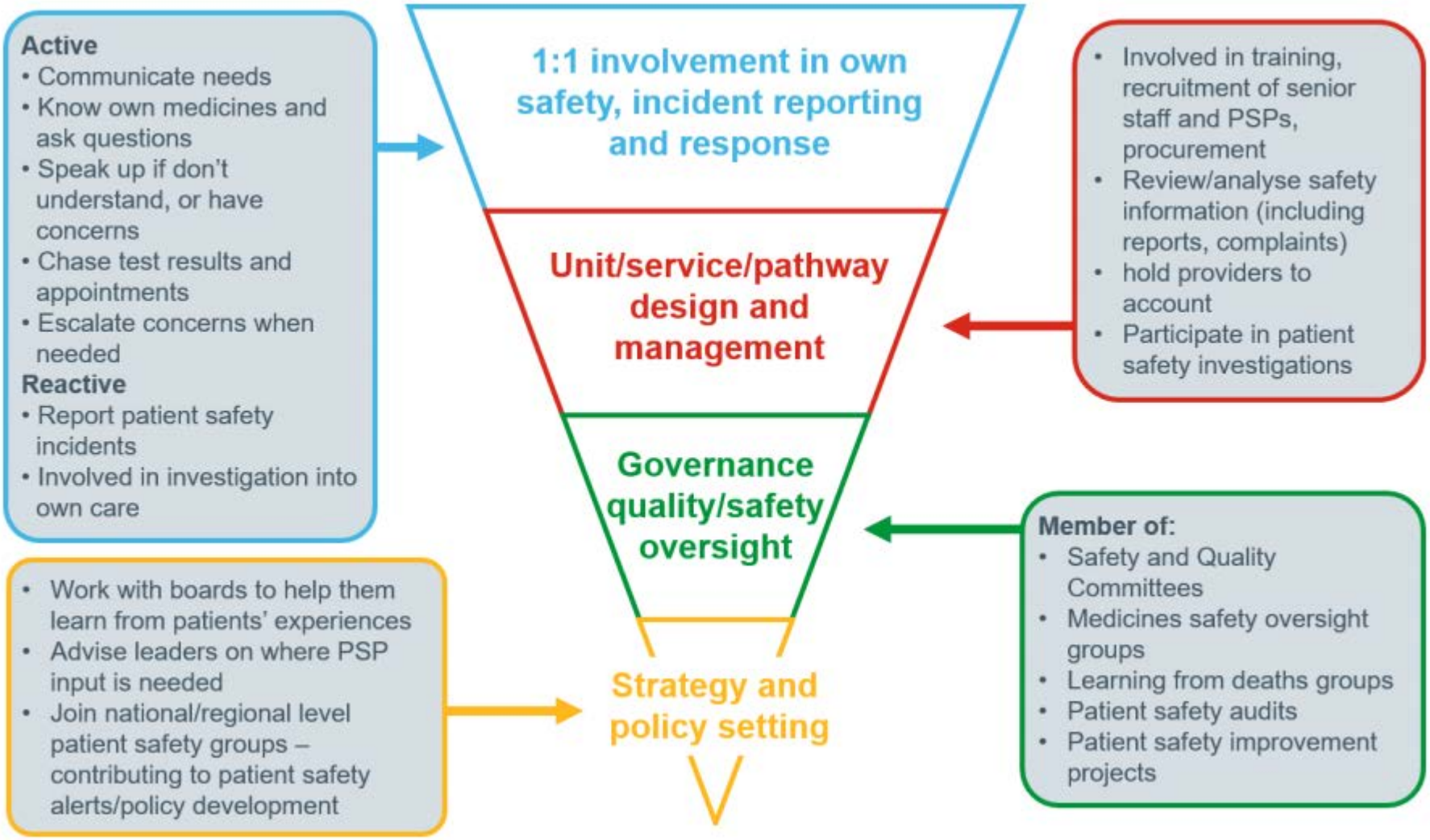
Potential roles for patient safety partners



Involvement

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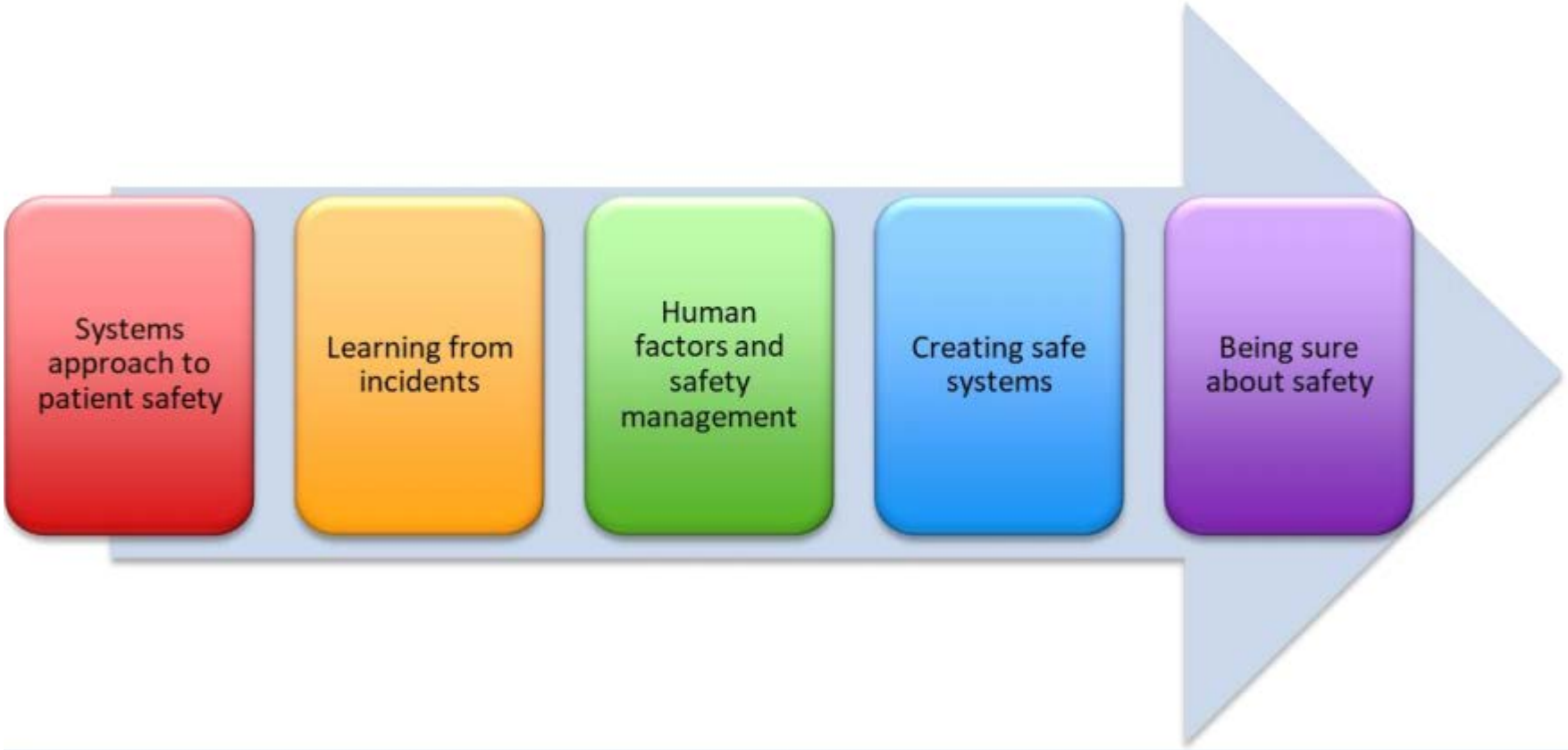
National patient safety syllabus



Involvement

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- **Patient safety specialists**
- Key leaders within systems (development of existing people/roles rather than new posts)
- Nominated by organisations by April 2020
- Developing a person spec of key attributes and role description with aim to professionalise role
- Not accountable for an organisations safety
- Development of patient safety networks
- Implications for the CCG
- CCG already has representation on the HIOW Patient Safety Partnership
- CCG has a number of individuals qualified to perform role with a track record of working with partners on safety/improvement projects

Improvement

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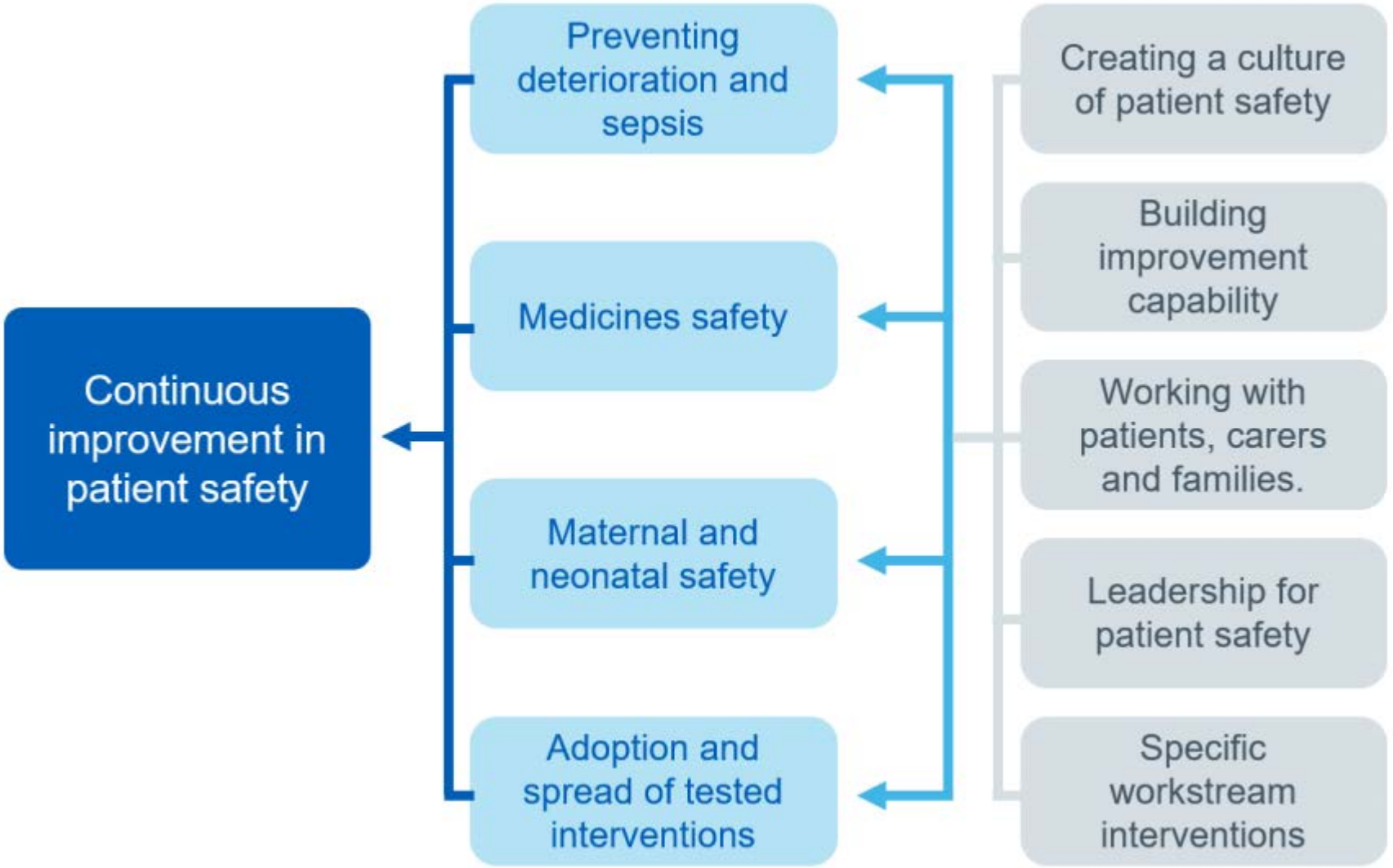

Primary Care

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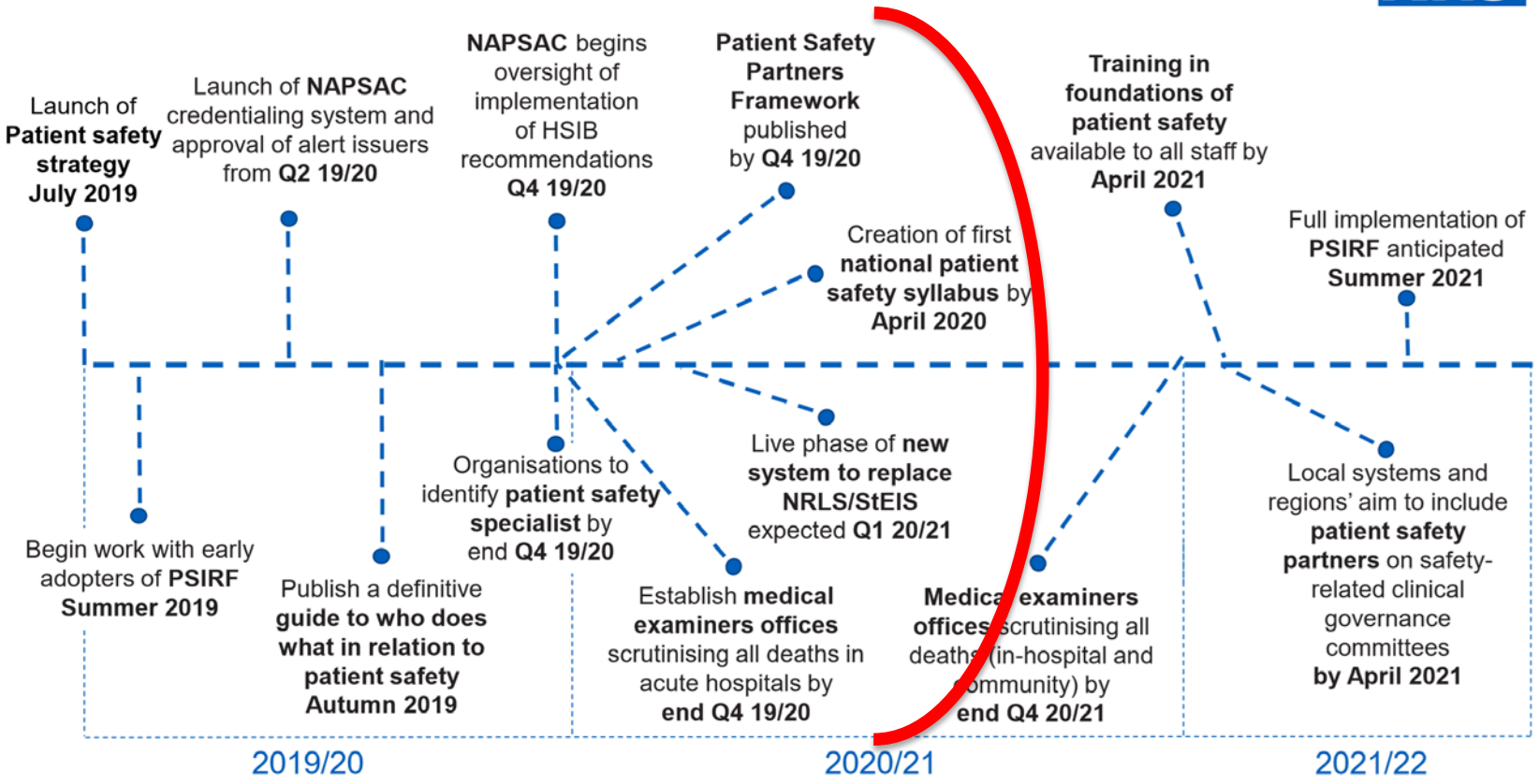
- Focuses on Primary Care culture and then need to spread applicable innovation from secondary to primary care
- Recognises that new primary care networks (PCNs) bring the opportunity to promote a safety culture and focus on continuous quality improvement
- The role of the PCN clinical director will be developed though leadership programmes to ensure they have the expertise to facilitate the strategy
- Once PCNs are established there will be potential to support the new safety initiatives in this strategy
- Implications for the CCG
- CCG is already ahead – CCG introduced DATIX reporting for NRLS into Primary Care, rolled out NEWS2 etc.
- Challenge is to build Quality Improvement capacity with PCN's

Delivery timeline for new initiatives



Conclusion

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- Step change in the thinking around patient safety
- Major focus on creating the right culture throughout the NHS
- Emphasis is on systems of safety rather than individual organisations
- Validates much of the focus the CCG and Quality Directorate has placed on culture, incident reporting, quality improvement
- Creates significant opportunities but will also create workforce and cost pressures
- Will be a period of significant change both operationally and culturally – CCG will be at the forefront in modelling and embedding this into systems (ICS/ICP, PCNs etc).