NATIONAL QUALITY BOARD

For meeting on: 05 December 2018

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Paper for:

Decision	Discussion	Information
	X	X

DEVELOPING THE PATIENT SAFETY STRATEGY FOR THE NHS

SUMMARY

This presentation introduces the NQB to the vision for a Patient Safety Strategy for the NHS which will sit alongside the NHS Long-Term Plan.

PURPOSE

The NQB is asked to:

1) **Note** the vision for a Patient Safety Strategy for the NHS; and

2) **Provide** initial comments on this in the context of the wider quality agenda.

ALB involvement in development and sign-off of paper:

NHS England	Care Quality Commission	NHS Improvement	NHS Health Education England
		X	

Public Health England	NICE National Institute for Health and Care Excellence	NHS Digital	Department of Health

NHS Improvement

Paper 3

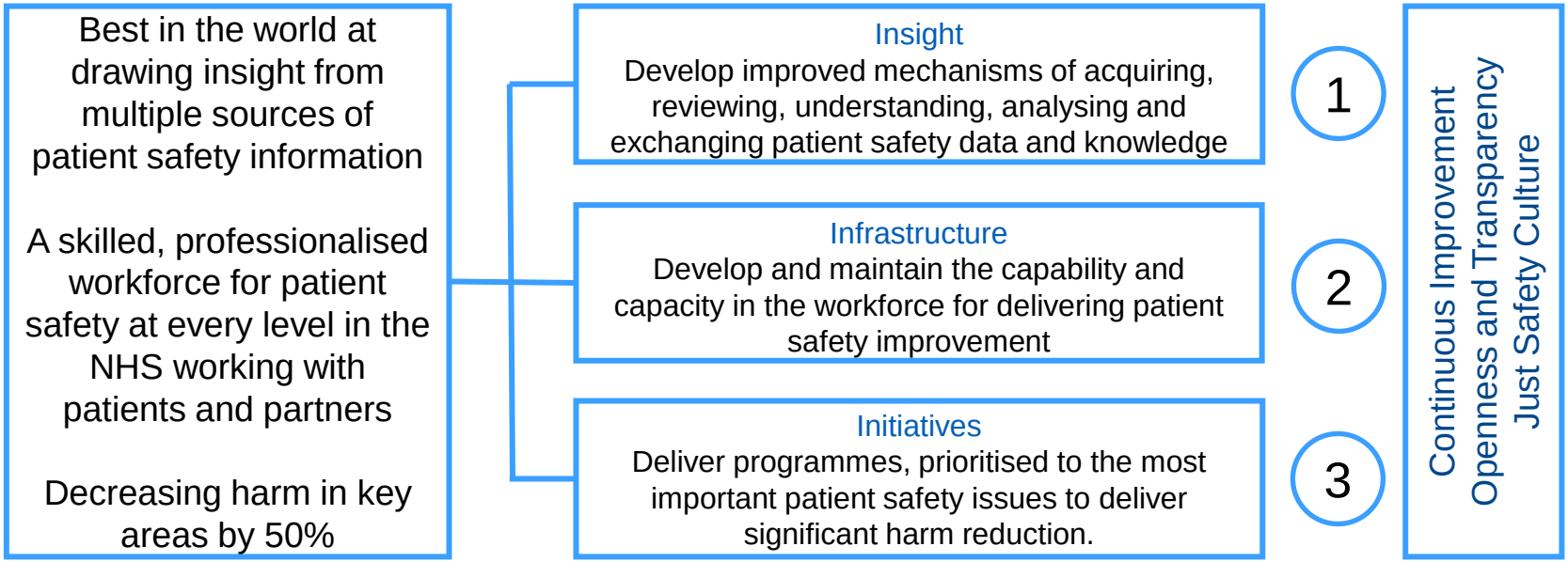
Developing the Patient Safety Strategy for the NHS

Presentation for the National Quality Board

5 December 2018

Towards a Patient Safety Strategy

Our ambition is for the NHS to be the safest healthcare system in the world



Insight

Develop improved mechanisms of acquiring, reviewing, understanding, analysing and exchanging patient safety data and knowledge

NHS Improvement

Insight now

The **National Reporting and Learning System** (supports statutory duties for NHSI and CQC). **Serious Incident & Never Event** reporting (StEIS). The national reporting system is uniquely capable of detecting themes, patterns and issues that require action but are not recognised locally.

Learning from Deaths/Mortality Review

Clinical Review and Response to identify new and under-recognised risks

Patient Safety Alerts to specify actions to mitigate risks and share resources

Review of patient safety data by Royal Colleges, MHRA, CQC, and researchers like Patient Safety Translational Research Centres

Insight of the future

All existing insight work plus

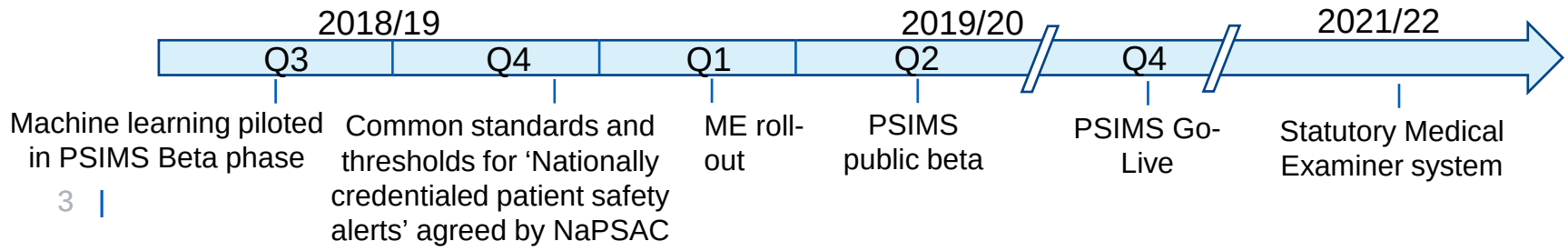
New **Patient Safety Incident Management System (PSIMS)** replacing the NRLS, StEIS & aligning with MHRA Yellow Card, eliminating duplicate reporting, supporting mobile device reporting, allowing more effective clinical review, exploring operationalisation of Safety II and supporting wider reporting including from **primary care**.

With added investment and exploration of machine learning, there is the potential to further increase insight and learning opportunities well above what is currently possible

Leading the new **National Patient Safety Alert Committee** (NaPSAC) for all ALBs, agreeing common thresholds and formats for safety-critical Alerts, reinforced by CQC inspection. Improved approach to alerts and alert implementation based on the recent CQC recommendations

Oversight of **HSIB recommendation** implementation and work to support improvement in the quality of **NHS investigations**

The **Medical Examiner** system (DH funded), reviewing all deaths, aligning mortality review programmes and increasing our capacity to learn



Infrastructure

Develop and maintain the capability and capacity in the workforce for delivering patient safety improvement

NHS Improvement

Infrastructure now

National PS team provides policy guidance for **serious incident management**, and some support for regional teams and providers. This supports providers to identify and deliver their own improvement actions.

But there is a lack of key senior link points within providers/localities to ensure Alerts, cultural resources like Just Culture Guide, and national initiatives carried through. There is also a lack of widespread and professional understanding of patient safety as a specialism.

Medication Safety and Medical Device Safety Officers (**MSOs/MDSOs**) are a model for potential national-to-provider/locality links but limited to specific topics

Regional NHSE and NHSI teams with Quality roles but not clear Patient Safety roles

Patient safety education, knowledge and skills remain limited at all levels and in all staff groups, including providers, commissioners and regulators (typically more fire safety training than patient safety training) resulting in bureaucratic and ineffective local efforts to improve safety

Infrastructure of the future

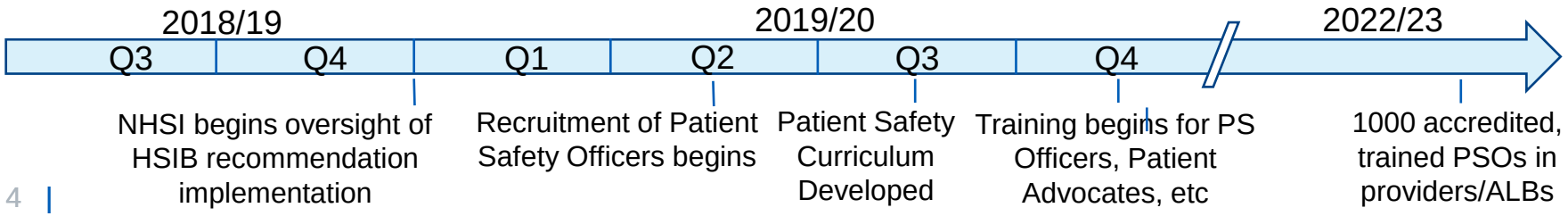
We will **align** the various Patient Safety roles of the national bodies to ensure **consistency and value**

We propose an additional investment in a new national **Safety Curriculum** that will ensure there is a **single language and approach** to patient safety from Board to Ward and nationally, and a network of senior **Patient Safety Specialists** who will be the backbone of safety in the NHS.

The NHS will be helped to recruit **patient advocates for safety** to ensure patients, carers and other non-health professionals are fundamentally involved throughout the system

NHS Regional Teams will provide support for safety improvement that is best delivered regionally or locally, and we will develop capability in **regulators** and **commissioners**.

A dedicated **Patient Safety Support Team** is proposed. They would be assigned to organisations that are particularly challenged in relation to safety. A central team would undertake an initial diagnostic using existing data and a bespoke safety culture and safety systems exploration, prior to co-producing and supporting implementation of a safety improvement plan.



Initiatives

Deliver programmes, prioritised to the most important patients safety issues to deliver significant harm reduction.

NHS Improvement

Initiatives now

Patient safety improvement programmes must balance working on small but very fixable patient safety issues with the larger but intractable long-term concerns. Solutions and strategies need to be evidence-based and underpinned by a theory of change that supports the creation of a clear measurement strategy. Starting point is to build on work already planned or underway;

Patient Safety Collaboratives developing QI capability and local priorities; recent focus on deterioration and culture

The Patient Safety Measurement Unit is becoming a key national resource (e.g. supporting sepsis improvement)

Maternity and Neonatal Safety Collaborative is key and aligned with the Maternity Transformation Programme

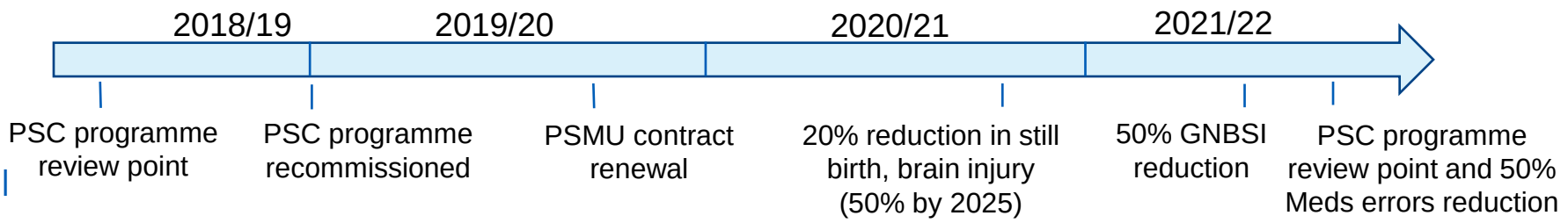
Intention to deliver **WHO 'medication without harm' challenge** and **Mental health PS programme** encompassing restraint and sexual safety; high ambitions but minimal PS resource

Clear ROI for some focused projects e.g. **stillbirth care bundle**, **NEWS** work impacting on **sepsis mortality**, **Emergency Laparotomy**, **PReCePT** etc. PiSCES independent evaluation of PSCs strongly recommends continuation of the programme

Initiatives of the future

Reductions in harm in key areas by 50% based on existing PSC work under a **recommissioned PSC programme,** and with development of further **national QI work** prioritised to areas with significant harm, variation, litigation costs, evidence base and the potential for wider impact. Including;

- Build on partnership work on **deterioration** including 7DS, Sepsis, NEWS2, PEWS, new tech for automating monitoring & escalation (represents 10% of overall harm i.e. £90M and 1100 lives)
- **Whole system falls and fracture prevention** inc. **Care Homes** with potential for just 10% improvement in delivery of evidence-based care to deliver £20m-£30m saving in annual £1,000M costs
- Building on **maternity and neonatal safety**, with emphasis on avoiding disability (£700M awarded p/a for obstetrics legal claims with cerebral palsy key factor). Explore **PROMPT, CTG training**
- **Medication Safety** programme and **Mental Health Safety Improvement Programme** and work to build on research on the nature and scale of problems in **primary care**
- Whole system approach to reducing **Never Events** building on CQC Thematic Review (NE costs estimated at £2.6M, 400 NEs/year)
- **Pressure Ulcer** and **Infection Prevention and Control** improvement work supporting Nursing Directorate to reduce E. Coli BSIs, PUs by 50%



Regional and local delivery

Based on the principle of devolving responsibility and leadership to regions and providers wherever possible while maintaining a single vision and only doing once what needs to be done once.

Central	Regional	Provider-based
Consistency of vision (eg just culture), theory of change, programme design + oversight	Consistent regional leadership and vision for delivering a just, safe culture through regional Patient Safety Specialists	Clinical Patient Safety Officers in every organisation
Understanding and solving problems once and avoid wheel reinvention (eg NaPSAC)	Infrastructure for safety improvement support – PSCs based on AHSN footprint	Accountability for day-to-day safety and improvement
Definitive source of patient safety information, advice (eg PSMU,PSIMS portal)	Mutual exchange of intelligence and broker collaboration on action	Safety Improvement Programmes Delivery – Maternity, Mental Health, Infection, Falls, Pressure Ulcers, Medication, Deterioration etc
Leveraging national influence and impact (eg HSIB recommendations)	Oversight for structural elements (eg Serious Incident Management)	Generate and share safety intelligence
	Coordination of delivery particularly cross-system (eg mortality review across primary/secondary/care homes)	Deep understanding of operations and local delivery

Engagement timescales

Developing our vision

Sep – Dec 2018

- Talking to key stakeholders
- Examining previous engagement responses, e.g. DPSIMS, SIF, patient safety references in LTP engagement
- Drafting our proposals

Engagement

Dec 2018 – Feb 2019

- Publish draft proposal and launch engagement webpage
- Online survey
- Regional workshops
- Stakeholder conversations (including online)

Implementation

April 2019 onward

- Finalise and publish patient safety strategy
- Support partners and providers to start implementing strategy