Annual progress report for the NHS Patient Safety Strategy: year one

September 2020

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Foreword

The intentions for year one of the NHS Patient Safety Strategy were to provide momentum and visibility to existing programmes of work, and kick-off initiatives to make the NHS even safer for our patients.

I am pleased to report that there has been strong progress on this, despite the obvious challenges of COVID-19. The ability of our hospitals and other services to deliver care safely was in evidence as around 110,000 patients got treatment for the virus.

The broad impact of COVID-19 in the second half of 2019/20 has nonetheless affected the pace of strategy implementation to a variable extent across the strategy.

As well as delivering safe patient care to tens of thousands of people, there have been a number of beneficial changes that have occurred throughout the pandemic as well including: increased flexibility; problem-solving at pace; and more collaborative team working in support of colleagues redeployed to the COVID-19 response and clinical services. In the case of medical examiners, and the strategy strands of Improvement and Insight, the respective teams pivoted their programmes rapidly to aid NHS COVID-19 management.

I would like to thank everyone who has participated in strategy implementation in this first year, including our patient safety partners and colleagues in other arms' length bodies.

By having a single, co-ordinated strategy, we have already added significant weight to individual measures all directed at making the NHS even safer for our patients, their families, and our colleagues.

We will build on these foundations in year two, which promises the realisation of several major strategy components such as patient safety specialists, patient safety partners and availability of the Patient Safety Incident Management System (PSIMS).

Aidan Fowler, NHS National director of patient safety

Safety system and safety culture

Increasingly, the culture of organisations – sometimes summarised as ‘what happens when no-one is watching’ – is recognised as a vital component in the safety of healthcare. Both systems and culture need constant nurturing and attention to support patient safety.

We have seen progress in systems development in the last year:

- local teams are working closely with national leadership, while NHSX is enhancing its work to make sure digital innovation embeds principles of patient safety in every project;
- the *We are the NHS: People Plan 2020/21* was fully informed by patient safety principles;
- with primary care continuing to be front and centre of people’s NHS – including face to face appointments being an ongoing requirement – we have involved those colleagues in our governance;
- we continue to work closely with regulatory and oversight colleagues, such as those in the Medicines and Healthcare products Regulatory Agency (MHRA), the Care Quality Commission (CQC) and NHS Resolution, to ensure risks and issues are appropriately identified and responded to.

While on a range of indicators, we can see strong, consistent progress in the past decade, we know we cannot simply change culture; we need to alter the ‘climate’ that people work in to support the development of the culture that we want to see. But the direction of travel is promising, with tangible successes.

Leaders of high performing organisations have shared their insights about how they support their organisations to exhibit a safety culture. As is often the case, while delivery may look different depending on the specific community, the principles underpinning local solutions are consistent, and they are the same as some of the principles that underpinned the remarkable NHS response to the COVID-19 pandemic: putting quality patient care first; the importance of strong relationships; effective communication and empowering people to do what they know is best for patients and our colleagues.

It’s this effort which has informed our drive to tackle poorer outcomes for women from black and ethnic minority backgrounds during pregnancy and labour, and why the NHS is right to continue to seek to prevent diabetes, which has been shown to contribute to worse COVID-19 mortality, and is disproportionately experienced by people from some ethnic minority communities.

A patient safety culture is one in which everyone feels psychologically safe and valued for what they do. Work is therefore underway to consider how to update the patient safety strategy to reflect the importance of promoting equality in patient safety. More detail will be set out in the refresh of the strategy due towards the end of 2020.

Matthew Fogarty, Deputy director of patient safety (Policy and strategy)

Table 1: Safety culture objectives

Objective	Who will deliver this	What and by when	Year one progress
Monitor the development of a safety culture in the NHS	National patient safety team	NHS staff survey q17 (fairness and effectiveness of reporting) and q18 (staff confidence and security in reporting), published annually every spring.	The NHS staff survey data has been preliminarily assessed.
		Explore the introduction of further metrics related to safety cultures, eg monitoring levels of staff suspension and of anonymous incident reporting.	The new Patient Safety Measurement Unit has been established.
		Monitoring progress in relation to the well-led framework via CQC inspection outcomes as published.	Links have been established with wider NHS culture work in the People Plan.
Support the development of a safety culture in the NHS	Local systems	Local systems to set out in their NHS Long Term Plan implementation plans how they will work to embed the principles of a safety culture. These should include monitoring and response to NHS staff survey results and any other safety culture assessments, adoption of the NHS Improvement A Just Culture Guide or equivalent and adherence to the well-led framework	Patient safety advice has been provided for development of the first local Long Term Plans. A safety culture 'toolkit' is in development to provide practical guidance for improving the safety culture in NHS organisations.

Table 2: Safety system objectives

Objective	Who will deliver this	What and by when	Year one progress
Publish a definitive guide to who does what in relation to patient safety	National patient safety team	Autumn 2019 and reviewed annually alongside the NHS Patient Safety Strategy annual update.	National arm's length bodies have been engaged in this work. A series of public and patient focus groups were held to define target audience and specific information needs, and this feedback is being reflected on.
Support workforce development through a new NHS People Plan	NHS England and NHS Improvement	Interim People Plan published June 2019. Full NHS People Plan to follow the next Comprehensive Spending Review.	The patient safety team have participated in the development of the People Plan 20/21 (published in August 2020) and the Leadership Compact. Collaborative work has begun on the Patient Safety Incident Management System to aggregate reports of violence against NHS staff at work.
Ensure understanding of patient safety is embedded across regulatory bodies	National patient safety team working with regulators	Encourage: • uptake of the new patient safety curriculum and training • contribution to the patient safety specialist network • commitment to patient safety partners	• Development of the new patient safety curriculum and training • Preparation for the introduction of patient safety specialists • Commitment to patient safety partners
Reflect patient safety in the digitisation agenda	National patient safety team working with clinical leaders, NHS Digital, NHSX and others	Make the safety case for the initiatives in Chapter 5 of the NHS Long Term Plan including: • EPMA implementation • record digitisation and data linkage • patient access to their records	Links have been established with the newly appointed team leading NHSX mission 4 (Patient Safety). Identification of rare/potentially under-recognised risks relating to digital technology continues.

		• clinical decision support.	
Enhance safety in primary care	National patient safety team working with primary care leaders	Include patient safety considerations in the NHS Long Term Plan initiatives around primary care, including primary care networks.	Patient safety considerations are being reflected in the NHS Long Term Plan initiatives, and the team have contributed to the national support offer for the development of local Long Term Plans.
		Expanding incident reporting to more of primary care by replacing the National Reporting and Learning System (NRLS).	See update on replacement of the NRLS in Table 3.
		Support primary care involvement in the National Patient Safety Improvement Programme (NPSIP) and related programmes as appropriate.	PINCER is the Pharmacist-led Information technology iNtervention for the reduction of Clinically important ERrors in medicines management. The AHSN has been commissioned to support 40% of GP practices in England to adopt PINCER (a new stretch target to be achieved by March 2021).
		Support the Keeping General Practice Safe component of the 2019 to 2021 GP IT operating model.	The national patient safety team support this programme and will progress this objective further in year two.

Insight

The national bodies that hold patient safety responsibilities have been brought together through the new National Patient Safety Committee, aligning work to tackle both urgent and long-term strategic challenges, and beginning to develop systems for oversight and arbitration of Healthcare Safety Investigation Branch (HSIB) recommendation delivery.

A key achievement has been mutually agreeing shared standards for National Patient Safety Alerts from all national bodies. Our own team became the first accredited issuer, and our colleagues in other alert-issuing bodies assessed whether we met the standards we had brokered. COVID-19 has shown this work is more vital than ever, so that healthcare providers know what critical patient safety issues need co-ordinated action with executive support. Robust processes have accelerated development of an effective Alert, and the standing advisory panel of patient and public representatives, frontline staff and national expert organisations have been superbly responsive in providing advice within hours.

Alongside continued clinical and analytical review and deeper dives into incidents reported to the National Reporting and Learning Service each year, we were delighted to review the first incidents reported via Patient Safety Incident Management System in its alpha stages. New medications, new equipment and new processes are where under-recognised patient safety issues are most likely to occur, and the response to the COVID-19 pandemic involved changes to all of these. Building on our learning from swine flu, we began proactively reviewing incidents referencing COVID-19 before the scale of the challenge was internationally recognised, alongside data sharing that supported the response to the pandemic within NHS England and NHS Improvement and by partners including the MHRA and royal colleges.

We continue to establish the case for new patient safety research, with major studies in primary care and prison healthcare progressing, and have enhanced the support we provide to researchers studying a wide range of safety issues through incident data.

Twice a year we publish our Insight ‘thank you’ report, detailing how incident data has been used to drive improvements in safety through our own work and the work of partners, and I’d like to extend my thanks to them all. The work we do nationally to collect, analyse and respond to information about patient safety incidents is entirely reliant on the hard work of our teams, extraordinary support from patient and

professional partners, and because staff at the frontline of delivering healthcare, and all the managers and executives supporting their work, continued to report issues that we could learn from. We are truly grateful for this team effort especially at the moment.

Frances Healey, Deputy director patient safety (Insight)

Table 3: Insight objectives

Objective	Who will deliver this	What and by when	Year one progress
Measurement	National patient safety team	Embed the principles of patient safety measurement nationally and work with other organisations to spread adoption.	The new Patient Safety Measurement Unit has been established. There has been continuing patient safety data sharing with partners such as CQC, the Safer Anaesthetic Liaison Group, the Faculty of Intensive Care Medicine and royal colleges. Specific data sharing and analysis has taken place for partners with key roles in the response to the COVID-19 pandemic.
Deliver replacement for the NRLS and Strategic Executive Information System (StEIS)	National patient safety team	Incorporate learning from what goes well (Safety II) in the development of the NRLS replacement.	The team have incorporated learning from what goes well (Safety II) in the development of the NRLS replacement. An extensive private beta phase has been undertaken, piloting the first iteration of the new service with a variety of provider organisations.
		Live phase of the new system is expected from Q1 2020/21 (subject to agile system development processes and Government Digital Service (GDS) approvals).	The PSIMS project has passed the GDS beta assessment. This kitemarks the outputs and development approach as being compliant with the GDS standard and provides a green light to proceed to public beta (open piloting).
		Ongoing provision of feedback to local systems to improve reporting, including by publishing national statistics (six monthly).	There has been ongoing provision of feedback to local systems to improve reporting, including by publishing national statistics (six monthly).
	NHS Resolution and the national patient safety team	Deliver an aligned Faculty of Learning to share insight from claims as part of PSIMS.	The Faculty of Learning website is in development and set to launch in September 2020. Six new learning modules are being finalised on consent, point of incident resolution for families, point of incident resolution for staff, learning from inquests, early notification maternity learning products, and scorecards to support trusts interrogate their data and learn from claims.

		Develop a shared taxonomy that will enable data analysis across databases.	New neonatal taxonomy codes were introduced in July 2020. Reviews are underway exploring further development and the refining of learning codes within the claims management system (CMS). A taxonomy for the GP indemnity scheme is also in development.
	Local systems	Local systems, including current non-reporters, to connect to the new system by end Q4 2020/21.	Extensive engagement with local reporting system providers has taken place to help ensure that they can connect to the new system by end Q4 2020/21.
		Continuous increase in effective incident reporting (note this is not the same as total incident reporting as the replacement for NRLS should improve quality without necessarily increasing quantity).	The trend of increasing NRLS reporting has continued consistently during the year, including throughout the emergence and peak of COVID-19.
Implement the new Patient Safety Incident Response Framework (PSIRF)	National patient safety team and regional teams, supported by HSIB	Establish PSIRF national implementation group in Q2 2019/20.	The PSIRF national implementation group is established and has resumed work following a short pause due to COVID-19.
		Develop investigation training supplier procurement framework by Q3 2019/20.	Work has begun to develop an investigation training supplier procurement framework.
		Develop resources for boards to support implementation, including incorporating relevant content into existing board development programmes by Q4 2019/20.	Support and resources have been focused on early adopter pilot organisations. A self-assessment readiness tool is helping boards to understand PSIRF early adopter commitments, and the specific requirements of boards within this.
		Regional team oversight roles and responsibilities aligned with the PSIRF by Q2 2020/21.	Regional roles and responsibilities regarding PSIRF are going to be tested and informed through the early adopter pilots.
		Work with early adopters across several local systems to gain insight into how best to implement the PSIRF.	The PSIRF was published in March 2020 together with patient videos. 25 early adopter organisations have been identified across all seven regions (covering acute, mental health, community, ambulance and independent care sectors).

	Local systems supported by regional teams	Local systems set out in their Long Term Plan implementation plans how they will implement the new PSIRF. Full implementation is anticipated by July 2021, informed by early adopter experience. Initially plans should: • identify PSIRF leads in local systems by Q4 2019/20 • anticipate development of organisational-level strategic plans for patient safety investigation and review by the end of Q2 2020/21 • ensure that leaders and staff are appropriately trained in responding to patient safety incidents, including investigation, according to their roles,[1] with delivery of that training and development from end Q2 2020/21 onwards • eliminate inappropriate performance measures from all dashboards/performance frameworks by Q2 2020/21 • as part of the organisation's quality governance arrangements, monitor on an annual basis the balance of resources for investigation versus improvement and whether actions completed in response to patient safety incidents measurably and sustainably reduce risk	The early adopter pilot phase that has started will inform how all local systems will incorporate the PSIRF.
Implement the medical examiner system	National patient safety team and regional teams	Recruitment of regional medical examiners and establishment of the medical examiner digital system by Q4 2019/20.	A new host has been appointed for the medical examiners digital system and started work to develop this in July 2020. The National Medical Examiner office and regional teams have been established. Good practice guidelines have been published. Reimbursement arrangements for

[1] Note: This training relates to currently available training in the specific skills required to effectively respond to patient safety incidents, particularly investigation skills. Wider work under the 'Involvement' section to develop and deliver a national patient safety curriculum and training will also incorporate relevant aspects of incident response, including investigation, but local systems should not delay work to ensure their existing staff are skilled to perform the roles they are asked to while the wider curriculum work takes shape.

			acute trusts have been rolled out. A series of National Medical Examiner bulletins have been issued containing advice and guidance. The National Medical Examiner office participated in the COVID-19 emergency response, including developing guidance to provide scrutiny of deaths of health service and social care workers who died from COVID-19.
	Acute trusts	Establish medical examiners offices scrutinising all deaths in acute hospitals by end Q4 2019/20.	We expect about 130 acute trusts to implement medical examiners, with around half having already begun to scrutinise cases. Some trusts temporarily paused implementation because of COVID-19. Trusts reported they had provided independent scrutiny of 56,654 deaths in 2019/20, In addition, 574 senior doctors have completed medical examiner training and 1,182 people have completed the e-learning modules.
		Ensure all deaths (in-hospital and community) are scrutinised by medical examiners by end Q4 2020/21.	COVID-19 has impacted on the roll-out to non-acute trusts. Opportunities to accelerate this aspect of implementation are being explored.
National clinical review and response	National patient safety team	Ongoing clinical review of and response to patient safety incident reports – including through publishing NHS Improvement Patient Safety Alerts.	The Insight team has continued clinical review and analysis of incidents reported to the NRLS, with an additional focus on COVID-19 related incidents so we can identify and quickly act on any new or emerging safety risks. We have added additional clinical reviews of lower harm incidents in areas directly relevant to the care of patients with COVID-19, and in areas where the response to COVID-19 could affect patients with other healthcare needs.
Implement the National Patient Safety Alerts Committee (NaPSAC)	National patient safety team	Credentialing system and approval of alert issuers from Q2 2019/20.	Eight accredited National Patient Safety Alerts have been issued by NHS England and NHS Improvement. 'Fast-track' National Patient Safety Alerts were issued in March and April 2020, confirming that full accredited standard can still be met when quick turnaround is needed. MHRA has been accredited and will issue accredited alerts from September 2020.

		Oversight of implementation of HSIB's investigation recommendations so that 100% are responded to and implemented or alternatives are in place from Q4 2019/20.	Oversight of HSIB investigation recommendation implementation was put on hold during April/May 2020, but a NaPSAC oversight pilot restarted in June.
	Local systems	100% compliance declared for all Patient Safety Alerts from Q2 2019/20.	Data analysis for National Patient Safety Alert compliance has started and will be published by MHRA.
Enhance the learning from litigation	NHS Resolution	Supporting the reduction in maternity incidents via the early notification scheme, CNST incentives, thematic reviews, claims scorecards.	New neonatal codes were introduced in July 2020. A safety and learning mediation role has been introduced and recruited to. Clinical fellows continue to work with the early notification maternity team to undertake clinical and thematic reviews. The CNST incentive scheme was temporarily paused in March 2020 due to COVID-19, and is due to be relaunched in Autumn.
	GIRFT	Continue programme to support improvements through claims learning including will publishing the first GIRFT best practice guidance on claims learning in orthopaedic surgery, focusing on the high-volume areas of hip and knee arthroplasty during 2019/20.	Publication of Best practice for hip and knee arthroplasty surgery documentation in collaboration with NHS Resolution. Feedback to the GIRFT and NHS Resolution litigation data packs was received from 137 trusts, including over 60 learning from claims reports. Nine orthopaedics and nine spinal surgery GIRFT litigation trust deep dives were conducted. Forthcoming publication of *Learning from litigation claims* in collaboration with NHS Resolution for clinicians and managers based on the trust visits and feedback from data packs. Litigation sections have been included in 20 national GIRFT reports, three of which have been published.

Involvement

The pandemic has created the opportunity to reflect on the real need for patient safety specialists in all NHS organisations, and their key role in ensuring patient safety is appropriately prioritised.

Specialists provide an important route for two-way communication between the national patient safety team and the rest of the NHS, as well as enabling rapid sharing of learning between organisations. We are now developing networks for patient safety specialists, and how they can support established and developing integrated care systems.

Recently, particular attention has been given to health inequalities and the lack of diversity in the NHS. An important way to address this is through increasing the involvement of a diverse mix of patients and the public in the running of their NHS organisations. This shows why the introduction of Patient Safety Partners is so important. The consultation on our draft Framework for Involving Patients in Patient Safety is ongoing but this presents a clear opportunity to support the equality agenda.

Another important point to note that has come out of our involvement work so far is that this work is going to have far-reaching and fundamental impacts on the success of our other strategy initiatives. For example, creating high quality education and training opportunities for patient safety specialists and patient safety partners will support the further development of the wider patient safety syllabus which is being led by Health Education England (HEE) and the Academy of Medical Royal Colleges (AoMRC). This in turn will have deep impacts on the ability of organisations to rise to safety challenges, to create the cultures that support continuous improvement and to ensure their staff are supported and enabled to do their best.

Joan Russell, Head of patient safety policy and partnerships

Table 4: Involvement objectives

Objective	Who will deliver this	What and by whom	Year one progress
Patient involvement in patient safety	National patient safety team and patient safety partners	Patient Safety Partners Framework published by Q4 2019/20.	The delivery group has been established, and the draft Patient Safety Partners Framework published for consultation. As part of the consultation process, focus groups have been held with patient representatives.
	Local systems	Local systems and regions aim to include two patient safety partners on their safety-related clinical governance committees (or equivalents) by April 2021, and elsewhere as appropriate, who will have received required training by April 2022.	Local system implementation will start once the framework is finalised. This programme is behind the original schedule due to COVID-19. The framework consultation is continuing, and new timelines will be determined.
Deliver a patient safety curriculum and syllabus that supports patient safety training and education for the whole NHS	NHS England and NHS Improvement and HEE	Evaluate current education and training packages, for inclusion or not in the national patient safety syllabus and create the first national patient safety syllabus by April 2020.	HEE along with the Academic Health Science Networks completed a mapping exercise of existing patient safety education and training. This will support the ongoing development of a set of quality standards and accreditation framework for the patient safety syllabus. A draft syllabus was published in January 2020 for consultation. 94 responses were received, with most providing positive feedback.
		Develop plans for implementing patient safety training in all relevant training and education by April 2020.	HEE has continued working with the AoMRC to develop the content, messages and channels for the Essentials (Level 1) and Access to Practice (Level 2) patient safety modules.
		Make training in the foundations of patient safety available to all staff by April 2021.	The training modules in development will be piloted during 2020/21.

	Local systems	Support all staff to receive training in the foundations of patient safety by April 2023.	Plans to support the delivery of patient safety training are in development.
Develop a network of patient safety specialists	National patient safety team	Initial role description available by Q3 2019/20.	The patient safety specialist delivery group has been established. A patient safety specialist requirements document has been developed.
		Hold the inaugural patient safety specialist network meeting in Q2 2020/21.	Initial discussions have been held with region safety leads, region directors and integrated care system leads about establishing and maintaining patient safety specialist networks.
	Local systems, regional and national healthcare organisations	Identify to the national patient safety team at least one patient safety specialist per organisation by end Q4 2019/20.	Consultation on the draft requirements document was completed, with about 180 responses received. This work is behind the original schedule due to COVID-19. However, there is recognition that implementation remains a high priority due to the value that patient safety specialists can offer their organisations in circumstances such as the pandemic response.
		Release patient safety specialists for identified training by Q4 2021/22.	Plans for supporting the delivery of patient safety specialist training are in development as part of the patient safety syllabus and curriculum project.
		Deliver training for 750 patient safety specialists by Q4 2022/23.	Plans for supporting the delivery of patient safety specialist training are in development as part of the patient safety syllabus and curriculum project.

Improvement

The safety improvement work is now spread across five national programmes. This has focused on how to implement evidence-based interventions to support patient safety across care pathways.

We have seen significant progress in some areas with more to come, including using national insights to design a more targeted improvement approach to specific safety concerns.

While most of this work is based on clinical interventions, there is a growing requirement that systems also give priority to several enablers that underpin the work, and invariably have led to success in year one. These include:

- Addressing inequalities and patient co-design: safety improvement interventions that represent the diversity and population served are co-produced and meet the needs of the most vulnerable in society;
- Capacity and capability building: alongside clinical training, the requirement to train clinicians and managers in quality improvement and safety science;
- Measurement for improvement: employing simple metrics that help us understand the baseline and the benefits of the improvement, allowing for rapid course corrections where interventions do not work, while minimising the data collection burden across the system;
- Safety culture: create the conditions for a safety culture to flourish;
- Safety improvement networks: build on existing networks to better share information and insights;
- Clinical leadership: ensuring that clinical leaders are identified and supported.

Phil Duncan, Head of patient safety improvement

Table 5: Improvement objectives

Objective	Who will deliver this	What and by whom	Year one progress
Enhance the impact of the National Patient Safety Improvement Programme (NPSIP)	National patient safety team, patient safety collaboratives (PSCs) and regional teams	Enhance co-ordination between the 15 PSCs and NHS England and NHS Improvement's regional teams through 2019/20.	Enhanced co-ordination has been achieved between the 15 PSCs and NHS England and NHS Improvement's regional teams. PSCs are working collaboratively on all developments with the patient safety improvement programmes. Regional NHS England and NHS Improvement colleagues now attend quarterly PSC assurance meetings. PSC colleagues are now co-leads within each safety improvement programme, assisting the senior improvement leads.
Deliver NPSIP priorities	Local systems supported by the national patient safety team and the PSCs	Deterioration – NEWS2 (National Early Warning Score) adoption by all acute and ambulance trusts by Q4 2019/20.	In Q4 2019/2020 NEWS2 uptake was at 100% for acute and ambulance trusts.
		Emergency laparotomy – 87% patients benefitting from the care bundle by Q4 2019/20.	97% of relevant sites have adopted one or more elements of the emergency laparotomy care bundle. Due to COVID-19 disruption of data reporting and collection, no patients benefiting figures were reported for Q4 2019/20. It is estimated that 21,450 patients may have benefited, which implies the yearly target of 87% patients benefiting would have been met.
		PReCePT (preventing cerebral palsy in preterm labour) – 33% increase in eligible mothers to whom $MgSO_4$ is given by Q4 2019/20.	PreCePT implementation has led to the 2019/20 an average 83% uptake of $MgSO_4$. This exceeds the national programme adoption and spread target of 73%.
		COPD (chronic obstructive pulmonary disease) discharge bundle – 50% increase in sites that use the care bundle over baseline by Q4 2019/20.	There has been an increase in the number of trusts adopting one or more elements of the COPD discharge bundle from the Q2 2019/20 baseline of 78/128, to 92% adoption.

		Emergency department (ED) checklist – 50% increase in acute sites that benefit from the ED checklist or equivalent over baseline by Q4 2019/20.	There has been a 50% increase in acute sites that have adopted the ED checklist from the Q4 2018/2019 baseline, with 76% adoption in Q4 2019/2020. This 50% increase represents the target being met.
Deliver the Maternity and Neonatal Safety Improvement Programme (MatNeoSIP)	Local learning systems and local maternity systems supported by the MNSIP team	Nationally reduce the rate of stillbirths, neonatal deaths and asphyxial brain injury by 50% by 2025.	All 134 maternity and neonatal care providers engaged with MatNeoSIP and undertook improvement work aimed at reducing the rate of stillbirths, neonatal deaths and asphyxial brain injury by 50% by 2025. Midwives, neonatal nurses, neonatologists and obstetricians received coaching and training in QI methodology to build system capability and capacity to improve and sustain change over time. The largest ever culture survey was completed across all maternity units, feeding into publication of the report *Measuring safety culture in maternal and neonatal services — using safety culture insight to support quality improvement*. Cultural insights were and will continue to be used to inform local quality improvement plans. The clinical leaders group was established, bringing together clinical leaders from across the country to support the development and leadership of maternal and neonatal safety improvement networks.
Deliver the Medication Safety Improvement Programme (MedSIP)	MSIP national programme team, PSCs and local systems	The programme will reduce avoidable medication-related harm in the NHS, focusing on high risk drugs, situations and vulnerable patients. Details to be confirmed	Engagement was undertaken with 500 national stakeholders to generate ideas and identify priorities. A medicines safety dashboard has been created. This shows times series data against programme priorities, available at aggregated national level and CCG level. A QI change bundle has been created around opioids. PSCs have worked on the engagement in care homes medicines administration QI and diagnostics. The results and recommendations of this work were compiled into a report. Through strong networks, the MedSIP has been responsive and reactive to emerging meds safety issues arising from COVID-19.

			A full baseline of all providers with electronic prescribing and medicines administration (ePMA – including mental health, community and specialist trusts) is in development.
Deliver the Mental Health Safety Improvement Programme (MHSIP)	Local systems supported by the MHSIP national programme team	MHSIP engagement programme – local systems should develop safety improvement plans post their engagement meeting (unless agreed not needed). National programme to deliver 33% reduction in restrictive practice in pilot wards by Q4 2019/20. All mental health inpatient providers nominate a ward to participate in the improving sexual safety collaborative. Data collection to be confirmed.	The MHSIP trust engagement work has been completed. During COVID-19 phase, change packages for restrictive practice and communications with carers were completed. A collaborative to improve sexual safety is being designed and will launch at the end of 2020. Draft sexual safety standards have been developed. COVID-19 has impacted on ability to deliver this programme to schedule.
Address safety issues that affect older people	NHS England and NHS Improvement supporting local systems	Continue to facilitate the Falls Collaborative Programme and improve falls prevention in hospital through the 2019/20 NHS Commissioning for Quality and Innovation (CQUIN) scheme. Spread uptake of the electronic frailty index and routine frailty identification and assessment. Link data on medications and falls. Continue the Stop the Pressure Programme. Spread Enhanced Health in Care Homes.	The Stop the Pressure Programme has delivered a revised definition and measurement framework, the launch of the national pressure ulcer audit, a new education curriculum, a national pressure ulcer improvement collaborative and nutrition improvement resources. Guidance was published in May 2020 in relation to prevention of pressure damage by staff who were wearing personal protective equipment and also in relation to patients developing pressure ulcers while being nursed in the prone position. The second version of the *Enhanced Health in Care Homes Framework* was published in March 2020.
Address safety issues that affect people with learning disabilities	NHS England and NHS Improvement supporting local systems	Accelerate LeDeR and align with the medical examiner system. Expand STOMP and STAMP. Further spread use of care and treatment reviews. All NHS-commissioned care to meet the learning disability improvement standards by 2023/24.	By June 2020 66% of the LeDeR reviews that were due for completion had been completed, with a further 27% in progress Guidance on learning disabilities has been issued for doctors completing medical certificates of causes of death. Specific guidance on how to support people with learning disabilities, and their families, during the COVID-19 pandemic, has been published and circulated

Deliver the UK National Action Plan for AMR	Local systems, supported by national and regional teams	Local systems should develop plans to: • halve healthcare-associated Gram-negative bloodstream infections by 2024 (25% by 2021) • reduce community antibiotic use by 25% (from 2013/14 baseline) by 2024 • reduce use of 'reserve' and 'watch' antibiotics by 10% (from 2017 baseline) by 2024 • improve the management of lower urinary tract infection (UTI) in older people in all care settings by Q4 2019/20 (supported by CQUIN) • improve antibiotic prophylaxis for colorectal surgery by Q4 2019/20 (supported by CQUIN).	The year-on-year increase of klebsiella, pseudomonas and *E. coli* infections has reduced in 2019/20 compared to 2018/19. Klebsiella cases increased by 3.5% (373 cases), pseudomonas by 3.5% (145 cases) and *E. coli* by 0.1% (33 cases). Antibiotic use in the community, specifically in primary care, has continued to reduce during 2019/20, continuing a six-year reduction trend, and remains on track to meet the 2024 target. Primary care use of broad-spectrum antibiotics has also continued to reduce to account for 8.2% of all antibiotic use. Further detail is reported by ESPAUR. The proportion of antibiotics classed as 'reserve' and 'watch' has reduced from 51.8% in 2018/19 to 50.3% in 2019/20. The CQUIN scheme 2019/20 delivered an improvement in the management of lower UTI in older people cared for in hospitals providing acute care. Improvement was reported within the scheme life and overall, 41% of cases audited in the scheme were compliant with all four care processes. 100/147 (68%) hospitals participated in the 2019/20 CQUIN scheme to improve antibiotic prophylaxis for elective colorectal surgery. Improvement was reported during scheme life and overall 82% of cases were compliant with the care process.
Support patient safety research and innovation	PSTRCs, AHSNs, other researchers, in conjunction with NIHR, DHSC and the national patient safety team	Develop new technical solutions to Never Events. Support the safety innovation pipeline more widely.	Research to explore the scale and nature of harm in primary care is completed and awaiting journal publication. Research to explore scale and nature of harm in prison healthcare is underway, though delayed due to the ethics approval process and COVID-19. The second assessment of 'adverse medical incidents and outcomes – understanding the experience, contexts, motivation and decision-making journey of patients who do and who do not make legal claim' – took place in April 2020. Human factors engineered design of electronic prescribing systems (with NHSX and DHSC) – Phase 1 literature review underway. Adverse medical incidents and outcomes research has been recommended for funding to the Central Commissioning Facility.

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

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