NHS Improvement

Developing a patient safety strategy for the NHS

Proposals for consultation

December 2018

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We support providers to give patients safe, high quality, compassionate care within local health systems that are financially sustainable.

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The purpose of this consultation

In September 2018, the Secretary of State for Health announced that a "new national patient safety strategy will mean safety is cemented into our long-term plan for the NHS".[1] Dr Aidan Fowler, NHS National Director of Patient Safety, confirmed that "Alongside the NHS's Long Term Plan… we are developing and will be engaging on a strategy for patient safety, which will build on our foundations to make sure people receive the safest care possible...''.[2]

This consultation document describes NHS Improvement's proposals for a national patient safety strategy. It is relevant to all parts of the NHS, be that physical or mental health care, in or out of hospital and primary care. While some measures are already underway, or represent an evolution of current work, some are new and wide-reaching. We want this strategy to reflect the views of the whole system, so we are seeking views from as many sources as possible.

Our proposals have been informed by what we have learned from the engagement around the NHS Long Term Plan, the Care Quality Commission's (CQC) review of Never Events, the work to review the Serious Incident framework, and the Gosport Inquiry and other inquiries such as those at Mid Staffordshire NHS Foundation Trust, and University Hospitals of Morecambe Bay NHS Foundation Trust. We are using insight from CQC's inspections and state of care report that highlights safety as the most significant concern across the NHS. And while our focus must be on reducing harm we must also consider issues like the increasing cost of litigation.

We are running an online consultation from 14 December 2018 until 15 February 2019. Please tell us what you think about our proposals using this route or, if you prefer, please email your views to patientsafety.enquiries@nhs.net. You can choose to answer all the questions or only the ones that interest you, but please do read all sections of this document first. An easy read version of this consultation document and the questions we are asking will shortly be available.

[1] https://www.gov.uk/government/speeches/patient-safety-no-room-for-complacency
[2] https://www.hsj.co.uk/quality-and-performance/hancock-announces-10-year-plan-for-patient-safety/7023460.article

Background

What is patient safety?

Patient safety is the avoidance of unintended or unexpected harm to people during the provision of healthcare. It is one of three core components of quality in healthcare alongside clinical effectiveness and patient experience.

Who are the national patient safety team?

NHS Improvement's national patient safety team provides clinical and non-clinical patient safety expertise for the whole NHS. The team sets policy direction and works with partner organisations like other NHS bodies, CQC and the Department of Health and Social Care (DHSC) to improve patient safety. It is led by the NHS National Director of Patient Safety who provides leadership for patient safety across the whole NHS.

The national patient safety team is responsible for delivering NHS Improvement's two statutory patient safety duties across the NHS. These are:

- **Collecting information about what goes wrong in healthcare:** patient safety incidents are reported to us through several routes but the main one is the National Reporting and Learning System (NRLS), which we manage and which receives around two million incidents reports a year. These reports are mainly from frontline healthcare staff. Reporting is vital to identifying and acting on risks. We encourage reporting and more reporting is expected as part of an improving safety culture.
- **Using information from incident reports and other sources to develop policy and provide advice and guidance:** "for the purposes of maintaining and improving the safety of the services provided by the health service" (Health and Social Care Act 2012, part 1, section 23, clause 13R). One of the main routes we use to provide 'advice and guidance' is through Patient Safety Alerts.

Our remit for patient safety extends to all areas of NHS-funded care in England – in short, wherever people use the NHS and whatever their diagnosis.

Where are we now?

The patient safety movement is about 20 years old and has made much progress in that time, but we know we still need to do more, including to reduce unwarranted variation.

In 2003 the NHS launched the NRLS, a world-leading incident reporting, review and response system. As a direct result of the national patient safety team's review of NRLS-reported incidents, the NHS has removed or reduced significant risks from across the system: for example:

- virtually eliminating accidental administration of high-strength potassium solutions[3]
- significantly reducing deaths from misplaced nasogastric tubes[4]
- introducing new devices that prevent the accidental administration of some drugs by the wrong route[5]
- improving the detection of acute kidney injury[6]
- removing error-prone and confusing syringe driver designs from use to prevent fatal opioid overdoses or uncontrolled pain in terminal care[7]
- ensuring all hospital staff can lift patients who fall and may have fractured bones in a way that does not cause further harm.[8]

The NRLS remains a valuable resource for the NHS, but to benefit from technological advances since its launch, it is being replaced with the Patient Safety Incident Management System (PSIMS), which will use new technology to better support our work to understand and reduce risks.

The NHS is becoming more transparent and open. Progress includes the creation of Duty of Candour requirements both for individuals and organisations, and the

[3] https://webarchive.nationalarchives.gov.uk/20171030132049/http://www.nrls.npsa.nhs.uk/resources/patient-safety-topics/medication-safety/?entryid45=59882&p=3
[4] https://improvement.nhs.uk/news-alerts/nasogastric-tube-misplacement-continuing-risk-of-death-severe-harm/
[5] https://improvement.nhs.uk/resources/small-bore-connectors-safety-introduction/
[6] https://www.thinkkidneys.nhs.uk/ https://improvement.nhs.uk/news-alerts/standardising-early-identification-acute-kidney-injury/ https://improvement.nhs.uk/news-alerts/resources-support-care-patients-acute-kidney-injury/
[7] https://webarchive.nationalarchives.gov.uk/20171030124641/http://www.nrls.npsa.nhs.uk/resources/type/alerts/?entryid45=92908
[8] https://webarchive.nationalarchives.gov.uk/20121107105239/http://www.nrls.npsa.nhs.uk/resources/type/alerts/?entryid45=94033

significant increase in both the range and depth of patient safety-related data and information the NHS publishes.

The NHS has an increasing awareness of important approaches to improving patient safety. These include: the role of systems thinking and design; the power of proactive risk assessment and hazard analysis; the value of human factors and ergonomics in improving systems and processes; and the impact of quality improvement methodologies through initiatives like the Patient Safety Collaboratives, the work of organisations like the Health Foundation and specific projects like the Emergency Laparotomy Collaborative.

But we know from recent engagement exercises, reports and reviews described below that we still face huge challenges in using these approaches, in being truly open and transparent, and in consistently improving safety across all parts of the NHS.

Our challenges

We know there are problems, for example, with how incidents are investigated and learned from. In our recent engagement to find out how we can improve the Serious Incident framework, people told us they were concerned about: providers' lack of capability and capacity to carry out good quality investigations; the tendency to use investigation for the wrong purposes; the generally poor approach to patient and family involvement; and the fact that actions to reduce risks after the completion of an investigation are too often ineffective.

We know from the Care Quality Commission's (CQC's) review of how the NHS responds to and learns from the care provided to patients who die that too often problems with care are not identified and the bereaved, who may have concerns, are not sufficiently supported.

Our own data shows that incident reporting from primary care is relatively low, and while primary care activity is lower risk than secondary care, we could do more to support reporting and learning in primary care.

We know from our work to support the CQC's thematic review of Never Events that organisations face problems implementing risk reduction actions and responding to incidents when they occur. Too many staff still fear blame, believing incident reporting is a punitive process. Others believe it is ineffective. They struggle to

prioritise and implement patient safety alerts designed to reduce risks. Staff want – but do not know where to get – support to make their organisation an ever-safer place for patients to receive care, and support to learn from when things go wrong in their organisation and elsewhere. Too few people can use the techniques and approaches mentioned earlier. Governance systems can be bureaucratic rather than responsive, too often focused on completing a process rather than supporting reduction of risk.

We know from the work to develop the NHS Long Term Plan that stakeholders believe we need to address several safety issues: the culture of fear and blame that stifles reporting and learning; the limited staff understanding of safety and associated topics like human factors and ergonomics; the administrative burden on clinical staff; insufficient support for staff and providers; and not enough staff overall.

All these themes chime with the messages from high-profile investigations and inquiries such as those at Mid Staffordshire, Gosport and Morecambe Bay: too many patients, families, carers and staff experience closed and defensive cultures when things go wrong in the NHS. Too often they are not supported in the aftermath of harm, including to understand what happened, and too often they have little confidence that the risk of similar harm will be reduced for others.

The NHS Long Term Plan is designed in part to address well-known pressures on the healthcare system that impact on patient safety – rising demand from a growing older population with complex healthcare needs, increasing costs of healthcare delivery and higher public expectations – with strategies on, for example, workforce planning, investment in infrastructure, service configuration and care integration.

The proposals in this document are designed to complement that wider plan and support the NHS to tackle safety-specific challenges and be the safest healthcare system in the world. These proposals are not the whole story however. We want respondents to tell us what else we and they can do to support this ambition, so we can produce a strategy for the whole healthcare system.

Our proposed aims and principles

We want the NHS to be the safest healthcare system in the world.

To realise this, our proposed strategy has three aims for the NHS. These are for the NHS to:

- be world leading at drawing **insight** from multiple sources of patient safety information
- give staff at all levels the skills and support they need to help improve patient safety, so they can be the **infrastructure** for safety improvement, working with patients and partner organisations
- decrease harm in key areas by 50% by 2023/24 and beyond through specific patient safety **initiatives**.

We also propose a focus on three principles that should underpin implementation of the strategy: **a just culture, openness and transparency** and **continuous improvement**. These encompass values and behaviours that are fundamental to delivering safe healthcare for patients. While they are not the only principles or ways of describing what should underpin a safety culture, we believe they are the most pertinent to the challenges we face. Together they should form a golden thread that runs through all aspects of healthcare from frontline provision and the interaction between patients and clinicians, to national leadership for the healthcare system.

A just culture

In his 2013 report *A promise to learn, a commitment to act*, Don Berwick advised the NHS to “abandon blame as a tool”. Evidence from across other industries and countries tells us that punishing people when they make mistakes will not mean they make fewer mistakes. It is wrong to believe that if people simply try hard enough, they will not make any errors. Blaming people for error does not improve safety. We should instead focus on changing systems and processes to make it easier for people to do their jobs safely.

That does not mean we should have a ‘no blame’ approach. While all but a tiny few people in healthcare come to work to do a good job and to help others, where people are deliberately malicious or wilfully negligent, action should be taken to protect patients and wider society. The safety response is separate from any sanction against the individual however and should focus on how to improve systems and processes to reduce the chances of these rare individuals harming patients.

Openness and transparency

To improve the safety of healthcare we must acknowledge the things that can, and do, go wrong and that we need to make changes. Talking about incidents where people were harmed can be uncomfortable. Not talking about them is dangerous. We must support everyone to be open and transparent, including with the patients who are harmed and their families and carers. Openness is a prerequisite for sharing insight about safety: being open supports the kind of positive accountability needed for change, as well as being the right thing to do.

Continuous improvement

Berwick also said that the NHS should be devoted to continuous improvement of safety. Fundamentally this means that improving patient safety is not a problem to be solved once and for all. Instead, working to enhance the reliability of how we provide healthcare should be a constant aim for everyone in healthcare.

We should never allow complacency to set in – everyone working in healthcare must always be aware of the potential for things to go wrong.

We must also apply the science of quality improvement. That means being clear about what we are trying to improve and how what we are changing will make things better, and then measuring the impact of what we are doing to find out whether we are having the desired impact.

We also need to empower NHS staff and patients to identify and then act on those areas where we can improve. This applies across primary and community care as much as across acute and mental health care.

Q1: Principles

A. Do you agree with these aims and principles? Would you suggest any others?

B. What do you think is inhibiting the development of a just safety culture?

C. Are you aware of A just culture guide?

D. What could be done to help further develop a just culture?

E. What more should be done to support openness and transparency?

F. How can we further support continuous safety improvement?

What we are proposing

For the NHS to be the safest healthcare system in the world we need a consistent focus on continuous learning and measurable improvement. This must be underpinned by a workforce and leaders who are enabled to deliver improvement in an open and transparent system that demonstrates a just culture. We propose delivering this through three priority areas of work that map to our three proposed aims: **insight**, **infrastructure** and **initiatives.**

Our proposed strategy is summarised in Figure 1 below.

Context

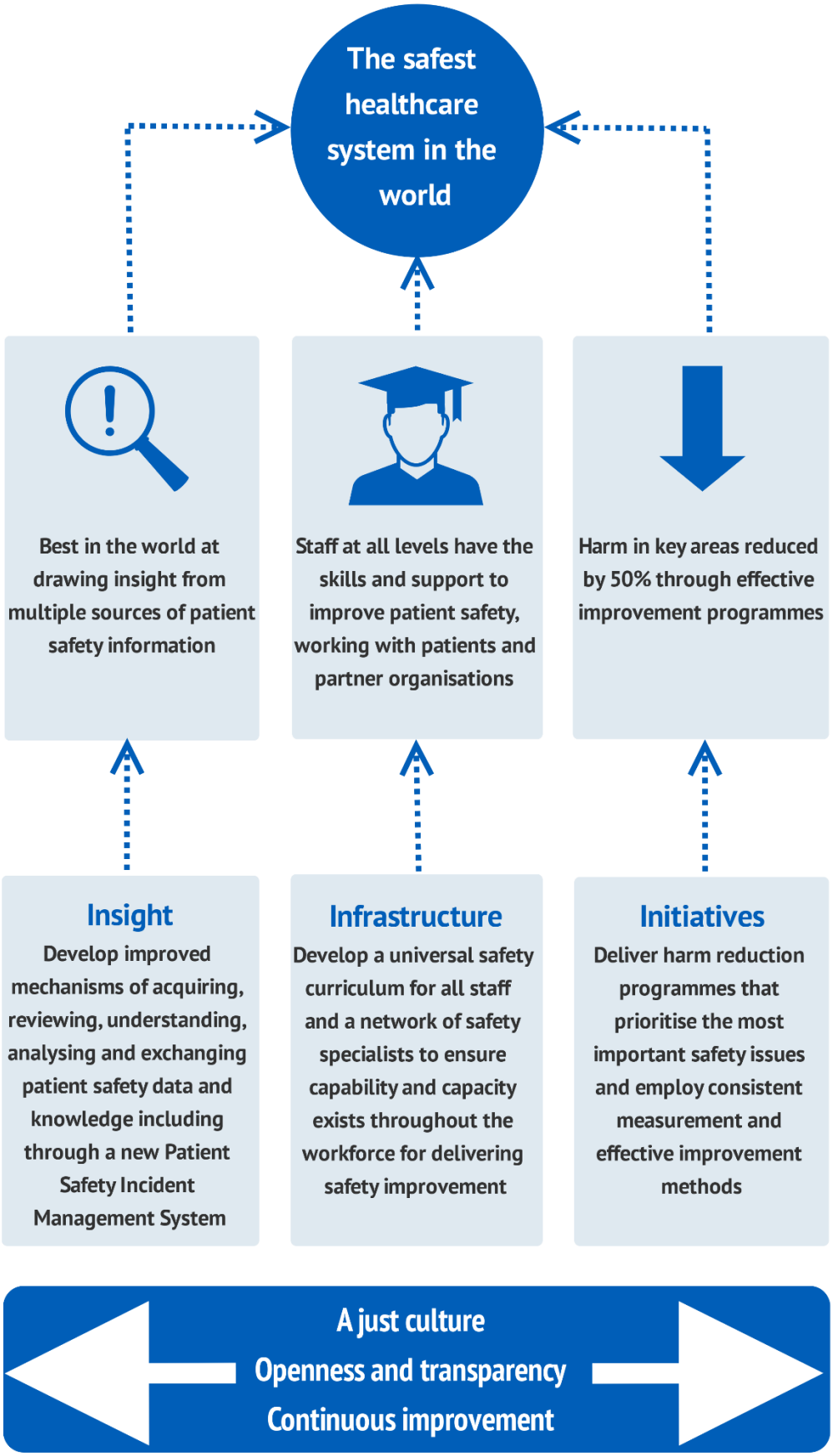
This is an important time for the NHS. Publication of the NHS Long Term Plan is imminent and we are changing how NHS Improvement and NHS England work together. Both organisations are committed to increased integration and alignment of national programmes and activities: NHS England and NHS Improvement regional teams are coming together into seven joint regional teams. This will help us break down boundaries between different parts of the NHS and between health and social care, which is particularly pertinent to improving patient safety.

By working together we will speak with one voice for the NHS in setting clear, consistent expectations for providers and local health systems. This will mean we can better support safety improvement, including through consistent measurement of safety across England and by demonstrating behaviours that embody the principles of a just culture, openness and transparency, and continuous improvement highlighted earlier.

The NHS system more widely is changing, with a move to integrated care and the formation of sustainability and transformation partnerships, and in some cases integrated care systems. Integrated care is a significant development for patient safety because it supports the arrangement of services around patients' needs. It also supports joint planning and delivery in a way that reduces the disjointed care that can increase risk – for example, from the complexities arising when a patient is transferred from one service to another.

It is important to consider the patient safety strategy proposals in this context.

Figure 1: Our proposed national patient safety strategy



Insight

> [noun] "[the ability to have] a clear, deep, and sometimes sudden understanding of a complicated problem or situation"[9]

The first of our proposed priority areas, **Insight**, incorporates NHS Improvement's statutory patient safety functions under the Health and Social Care Act 2012 (see earlier). But we intend to further improve the way that we fulfil these duties to become the best in the world at drawing insight from multiple sources of patient safety information.

Around two million incidents are reported and managed within healthcare providers every year, with most reporting across acute, mental health and community care. Our national database (the NRLS) also allows those incident reports to be collated centrally for the purposes of learning but it is not possible for the national patient safety team to read every one. We read those reporting the most significant harm and use that information to search the NRLS for additional information. We could get even more benefit from nationally-reported incident data if we harnessed new technologies such as artificial intelligence and machine learning to interrogate the data. We could also use new techniques to explore enhancing what goes well in healthcare rather than preventing what goes wrong, a concept known as 'Safety II'. This is what the new Patient Safety Incident Management System will give us the potential to do.

The system will also make reporting easier and more rewarding, increasing our insight from the parts of the NHS, like primary care, that find it harder to report.

We are clarifying and standardising how we provide safety critical advice and guidance to the NHS, work led by the new **National Patient Safety Alerts Committee (NaPSAC)**. NaPSAC is using the findings of CQC's thematic review of Never Events and work by the national patient safety team and the Medicines and Healthcare products Regulatory Authority (MHRA) to redesign the format of and standardise the criteria for the development of patient safety alerts. This will clarify what is expected of providers and local systems and improve their understanding and ability to implement safety-critical actions. NaPSAC will become a cross-system safety committee akin to those in other sectors, to support the whole health

[9] *Cambridge English Dictionary*

and care system response to the recommendations from Healthcare Safety Investigation Branch's (HSIB's) investigations.

We will also use the evidence we have gathered as part of the review of the Serious Incident framework and work with HSIB to **improve the quality of safety investigation** and help providers and local systems generate their own insight.

The government has decided that the new Medical Examiner system will be located with the national patient safety team and report through the NHS National Director of Patient Safety to the combined boards of NHS Improvement and NHS England. This system will enhance the scrutiny of death certification to detect concerning patterns of death and support referral of cases to NHS patient safety systems. It will help co-ordinate and align mortality review work in the NHS, including existing efforts to deliver the Learning from Deaths policy, providing a crucial source of safety information to inform national work, as well as improving how the NHS supports the bereaved.

The closer working between NHS England and NHS Improvement gives us the opportunity to ensure data is used in a consistent way across the NHS to understand patient safety. This approach must include making full use of data from national clinical audits and the clinical outcome review programmes.

Q2: Insight

A. Do you agree with these proposals? Please give the reasons for your answer.

B. Would you suggest anything different or is there anything you would add?

Infrastructure

> [noun] "The basic underlying framework or features of a system, or organisation that enable it to function."[10]

[10] *Collins English Dictionary*

People are the most important **infrastructure** for patient safety in the NHS. Improving patient safety requires people to have the skills and ability to act effectively to reduce risk. Our existing systems encourage improvement through, for example, oversight of Serious Incident investigation and safety surveillance activities. But progress is being held back by insufficient patient safety education, knowledge, skills and understanding at all levels and in all staff groups.

This was clear from, for example, our work for CQC's thematic review of Never Events, which also looked at wider safety systems in the NHS and the ability to respond effectively to patient safety alerts designed to reduce risks. We saw that people are at the heart of patient safety improvement, but that: insufficient patient safety understanding; a limited ability for those who create patient safety alerts to work directly with senior safety leads in every provider; and inconsistent approaches across NHS England, NHS Improvement and CQC all increase the bureaucracy and can decrease the effectiveness of efforts to improve safety. Recent HSIB investigations found similar concerns.

The lack of patient safety understanding limits the impact of patient safety alerts and national policies like the Never Events framework and wider Serious Incident framework. To address it we propose:

- Cross-system development of a shared and consistent **patient safety curriculum** for all current and future NHS staff that can be appropriately tailored to suit different needs. This will promote understanding of patient safety among NHS staff and those in training to work in healthcare: they will know what language and techniques to use, meaning greater alignment and efficiency. The same curriculum can be used to train interested patients and other lay representatives.
- Development of a network of **senior patient safety specialists** in providers and local systems to become the backbone of patient safety in the NHS. We also propose having these patient safety specialists in NHS regional teams, regulators and commissioners to ensure consistency of approach to safety improvement, governance and accountability. These roles should not be filled by recruiting new staff, but rather by identifying existing staff who are already working in safety-related roles, be they nurses, doctors, pharmacists, managers or allied health professionals, and who can be supported to become these skilled specialists. Alongside these

specialists, we will help the NHS recruit **patient advocates for safety** to ensure patients are heard throughout the system.

- To establish a dedicated **patient safety support team** that can be assigned to organisations that are particularly challenged in relation to safety. A small team could help a provider understand the causes of their challenges, and then support improvement alongside the regional team. We believe a dedicated support function offered in a non-judgemental way would be welcomed by the system.

Increasing understanding of patient safety across healthcare will not only increase technical knowledge and skills, it can also create the conditions for a **patient safety culture** to develop further. We know the culture of organisations is critical to patient safety, but we also know we cannot simply make culture change happen. Our proposals for patient safety education and training for all NHS staff, and the introduction of safety specialists, including in NHS regional teams and regulators, will spread understanding of the principles, values and behaviours that support a good patient safety culture. As people learn about the key concepts that underpin patient safety, they will be able to recognise behaviours and approaches that do not help and instead adopt those that do support patient safety.

Q3: Infrastructure

A. Do you agree with these proposals? Please give the reasons for your answer.

B. Would you suggest anything different or would you add anything?

C. Which areas do you think a national patient safety curriculum should cover?

D. How should training be delivered?

E. What skills and knowledge should patient safety specialists have?

F. How can patient/family/carer involvement in patient safety be increased and improved?

G. Where would patient involvement be most impactful?

H. Would a dedicated patient safety support team be helpful in addition to existing support mechanisms? If yes, how?

Initiatives

> [noun, plural] “An act or strategy intended to resolve a difficulty or improve a situation; a fresh approach to something.”[11]

We propose committing to reducing the amount of harm caused in key areas of patient safety by 50% by 2023/24 and beyond. We know that measuring harm and patient safety is very challenging and that accurate data on the total level of harm in the NHS does not exist. This means we cannot set a universal ‘target’ for safety improvement. But we also know that we can measure specific objectives for safety improvement as long as we establish good measurement strategies focussed on clearly described issues. In some areas, objectives have already been set (see below). We are therefore proposing that wherever we establish safety improvement initiatives, that our default ambition should be to reduce measurable harm by 50%. This general level of ambition, although stretching, is appropriate.

We would prioritise programmes where the most significant harm is seen, litigation costs are highest, unwarranted variation is greatest, and evidence-based interventions are known to mitigate risk. We would be guided by experts such as professional associations, royal colleges, frontline clinicians, patient representatives and the Patient Safety Translational Research Centres when choosing and prioritising.

The main route for delivering these initiatives would be the Patient Safety Collaboratives (PSC) programme. Our recently commissioned review of this programme[12] recommends its continuation but with a more consistent and

[11] Oxforddictionaries.com
[12] This will be published shortly on our website.

structured approach. A key part of this will be better alignment of the PSC programme with the seven NHS regional teams that are being created as part of NHS Improvement's and NHS England's commitment to integrate regional structures. This will enhance improvement activity, support efforts on innovation and spread, and along with more consistent measurement of improvement, mean that providers and local systems will have clearer and more consistent support.

Already underway as part of the PSC programme are initiatives looking at **deterioration**, including **sepsis** and **National Early Warning Score 2** (NEWS2) implementation which can in turn impact on avoidable cardiac arrests and other outcomes.

The PSC programme supports the maternity and neonatal health safety collaborative programme which contributes to the ambition to halve the number of stillbirths, neonatal and maternal deaths and brain injuries by 2030.

Significant new work on **medication safety** aligned with the World Health Organisation's Medication Without Harm challenge is being planned. Whilst the interventions are not yet decided we know which medicines, patients and processes are highest risk and that there is a need to intervene to reduce harm in these areas.

We also intend that this programme should link to the important work on **anti-microbial resistance** which is an increasing and significant global safety challenge. Our contribution to safe and appropriate use of antimicrobials is key and plans such as the role out of electronic prescribing systems are set to help. Alongside this, efforts to improve **infection prevention and control (IPC)**, including reducing cases of healthcare-associated Gram-negative bloodstream infections by 50% by March 2024 are crucial, as is work on improving diagnostics and stewardship.

The PSC programme is also looking at **spread and adoption** of successful safety interventions such as the emergency laparotomy bundle.

Outside the remit of the PSC programme are several important safety-related programmes of work. These include work on **maternal and neonatal health** which is focussing on obesity prevention; proactive measures to ensure women in preterm labour nationwide are given magnesium sulphate (an evidence-based practice for reducing incidence of cerebral palsy in their babies); and ensuring preterm birth occurs in the appropriate setting for mother and baby. Improving maternity care is a

key objective in the NHS Long Term Plan and we will ensure work on maternity safety aligns with wider maternity care improvements.

We will continue to facilitate the **falls collaborative** programme. From 2019 to 2021 we will offer bespoke support to providers identified in the national falls audit as having improvement needs. Alongside this the national falls practitioner network will facilitate sharing of best practice through regular events and conferences, and links will be strengthened with related work – for example, on enhanced care and observation.

The **Stop the Pressure programme** (STPP), started in 2012 in the Midlands and the East Region, launched as a national programme in 2016 to reduce the incidence and severity of **pressure ulcers**. This work has already delivered a revised definition and measurement framework, a new education curriculum, a national pressure ulcer improvement collaborative and nutrition improvement resources; by March 2019 bespoke improvement resources for specialist clinical areas and workforce will be available for all provider settings. Since September 2018 the STPP has been linked to the new national wound care strategy which extends it beyond hospitals and into primary care, domiciliary and social care settings. This national strategy concerns the development of relevant pathways of care, education and approach to data, focusing on improving the care of lower limb and surgical wounds. We anticipate working to improve productivity through better ulcer healing rates and review of the supply chain, public information materials and evaluation of the published framework and curriculum.

We will use our learning from previous **nutrition** collaboratives to provide further improvement initiatives on nutritional care to support the national wound care strategy during 2019: improvement collaboratives, trust visits and topic-specific masterclasses and webinars.

Work on **mental health** safety improvement has begun, including on reducing the use of restraint and the ambition to prevent all inpatient suicides. NHS England has established a programme of work on reducing restrictive practices interventions across NHS-commissioned services delivering mental health and learning disability care. This work currently covers improving the capture of data on restraint, improving restraint training and a focus on using quality improvement methodology to reduce restrictive practice. Similarly, joint work between NHS England, NHS Improvement, Public Health England and DHSC to reduce and prevent suicide is

underway. While this work is not solely about patient safety, there is significant overlap and indeed several other initiatives are planned or underway. As part of the safety strategy we propose supporting the alignment of relevant mental health safety improvement work to ensure clarity and delivery.

Other areas we believe deserve attention are those with high **litigation costs** such as care in emergency departments, orthopaedic surgery and primary care diagnosis. For primary care we also anticipate significant work to respond to the findings of research we commissioned through the DHSC Policy Research Programme into the scale and nature of significant avoidable harm in primary care.[13]

We will continue to work with partners to mitigate risks, notably those for **Never Events**, and develop a toolbox for preventing each type. Innovative ideas include smart or radiofrequency identification (RFID) swabs that help avoid their unintentional retention following surgery. We will explore how we can support the spread and adoption of those innovations that demonstrate cost-effective safety improvement.

Q4: Initiatives

A. Do you agree with these proposals? Please give the reasons for your answer.

B. Would you suggest anything different or do you have anything to add?

C. What are the most effective improvement approaches and delivery models?

D. Which approaches for adoption and spread are most effective?

E. How should we achieve sustainability and define success?

[13] These findings will be published shortly.

Conclusion

We believe the NHS is uniquely positioned to be the safest healthcare system in the world. The proposals in this document set out some of our ideas for how we can realise that ambition, but we need the help of the wider NHS, patients, the public, academics, leaders, frontline staff and other experts to help us further develop our plans.

Some of what we have set out is already underway, such as the work to develop the new Patient Safety Incident Management System and the creation of the National Patient Safety Alerts Committee. Some proposals represent the evolution of work that has been ongoing for some time, such as the Patient Safety Collaborative programme. And some of the proposals here are new and wide-reaching including: development of a consistent curriculum for patient safety training for all current and future NHS staff that can be tailored according to role and for lay representatives; and the development of patient safety specialists across all NHS providers, local systems and other NHS bodies.

We recognise a system-wide effort is needed to deliver the ambitions we have set out. This is why input from across the system at this stage is so important to ensuring we produce a national patient safety strategy that is right for all parts of the NHS.

Our consultation page will be open for comments until 15 February 2019. Your responses will inform our national patient safety strategy, to be published in spring 2019.

If you have any other comments or queries, please contact us at patientsafety.enquiries@nhs.net

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