



The NHS patient safety strategy

NHS England and NHS Improvement's joint paper *The NHS patient safety strategy: Safer culture, safer systems, safer patients* (July 2019) is the culmination of a two-year paradigm shift in the way the NHS treats patient safety. The transformation of the NHS Litigation Authority into NHS Resolution, creation of the Health Service Investigations Branch, upcoming reforms to clinical negligence claim handling are all indicative of a move away from a culture of blame to one of learning.

The Secretary of State for Health and Social Care has positioned patient safety as 'a golden thread' running through everything the health service does, with the improvement of safety to be tied to advancements in technology and improvements to staff and patient engagement.

Key changes

Fundamentally, this strategy sets out a new framework to enable a culture transition from blame to learning. It envisions an approach where patient safety initiatives and responses are primarily based on what can be learned rather than who should be held accountable, notwithstanding wilful and malicious negligence. Underscored by the principles of insight, involvement and improvement, the strategy recognises that there is no endpoint when it comes to safety. The strategy defines these principles as follows:

Insight – Improving understanding of safety by drawing intelligence from multiple sources of patient safety information.

Involvement – Equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system.

Improvement – Designing and supporting programmes that deliver effective and sustainable change in the most important areas.

To this end, it outlines a process of continuous improvement where NHS patient safety systems are well positioned to respond to patient needs and system priorities in a dynamic way – constantly searching areas of improvement in partnership with national bodies, patients, staff and NHS organisations.



In addition to broader changes in the way the NHS thinks about patient safety, the document outlines a number of more specific initiatives tasked with improving individual aspects of the patient safety framework:

Patient safety incident response framework – This system will make reporting easier and more rewarding, providing a platform for insights from all parts of the NHS. It will be deployed in an attempt to enhance what goes well rather than just focussing on what goes wrong and will draw upon artificial intelligence and machine learning to better enable national bodies to sift through incident reports and identify trends. Crucially, it will focus on what goes right rather than what goes wrong.

Medical examiner system – The creation of a medical examiner system (MES) aims to improve safeguarding, quality of certification and quality of care in the NHS by creating a network of medical examiners operating independently from trusts to scrutinise and sign off all deaths across a local area. This system will sit within NHS Improvement’s patient safety team and the examiners themselves will be expected to take up membership of the Royal College of Pathologists.

National Patient Safety Alerts Committee (NaPSAC) – The creation of NaPSAC is intended to lead the redesign and standardisation of patient safety alerts. They will also take on responsibility for supporting local systems to respond to and implement findings from the Healthcare Safety Investigations Branch (HSIB)* as well as working with them and directly with providers to improve the quality of local investigations.

Patient safety partners (PSPs) – These roles will be created across all trusts in England, drawing on patients, their families and carers to help improve safety in the NHS. PSPs will not be employees of the trust as such but will be remunerated for their work. They will work at a number of levels, at the most basic level this means taking responsibility for their own safety and at higher levels, advising boards and sitting on regional safety groups.

Patient safety specialists (PSS) – A network of senior PSSs in providers and local systems will become ‘the backbone’ of patient safety in the NHS. These roles will sit in providers, systems, regional arm’s length bodies, regulators and commissioners. These roles will not be filled by recruiting new staff but should instead identify existing staff who can be supported to become specialists.

*HSIB is currently tasked with undertaking independent investigations into breaches of patient safety which, pending the passage of bill through parliament, would take on new powers to become the Health Service Safety Investigations Body (HSSIB).

A closer look at the strategy

The strategy is divided into three key areas, with each of these highlighting a number of changes that the NHS will need to undergo in order to improve patient safety:

- **Insight**
- **Involvement**
- **Improvement**

Insight

The patient safety incident response framework

The new patient safety incident response framework (PSIRF) will replace the serious incident framework and will dictate the terms under which NHS organisations investigate and report cases where there has been a breach of patient safety.

Proposals include:

- taking a broader system approach looking at principles, systems processes, skills and behaviours for incident management
- improving transparency and support for those affected by patient safety incidents
- adopting a risk-based approach to allow organisations to select incidents for investigation based on the opportunity they provide for learning and ensuring that sufficient resources are allocated to implement any improvements based on finding.
- insulating safety investigations against 'scope creep' to ensure they are not used to judge on avoidability, predictability, liability, fitness to practice or cause of death but instead focus exclusively on learning.

The medical examiner system

Medical examiner offices will provide:

- a better service for the bereaved
- enhanced scrutiny of circumstances around deaths
- signal relevant deaths to the coroner
- improving the quality of death certification.

They will be introduced as a non-statutory function but is intended to be enshrined in statute by the Department of Health and Social Care (DHSC) in due course.

In 2019/20, acute trusts are being asked to establish medical examiner offices to:

- agree the proposed cause of death with relevant practitioners and ensure accuracy of death certification
- discuss the cause of death with next of kin and discuss whether they have any issues with the care provided (in non-coroner cases)
- consult with the local coroner on medical issues and facilitate notification of deaths to them.

The rollout of medical examiners services to community and independent providers is expected to take place over the course of 2020/21.

At the local level, medical examiner offices will shape the development and focus of mortality review and clinical governance processes according to their findings.

National Patient Safety Alerts Committee (NaPSAC)

NaPSAC is working to develop a standard format for all alerts which will bring into line all those bodies who issue safety alerts and support them to adopt a single format. NaPSAC will also take on responsibility for overseeing the implementation of HSIB recommendations and holding responsible organisations to account on their progress in implementing these recommendations.

The intention is that these combined measures will make it easier for local systems to understand what measures to take, deadlines around these measures and the purpose of changing their processes.

Involvement

Patients safety partners (PSPs)

The creation of PSPs will enable NHS organisations to more closely reflect the needs and views of patients, their families and carers when it comes to safety. The strategy envisions widespread adoption of these roles across the service, with formal role descriptions outlining what they might be expected to do.

Four potential tiers of involvement are suggested:

1. Involvement in own safety, incident reporting and response – PSPs at this level will be involved largely in safety issues related to their own standards of care and might expect to report patient safety incidents and participate in investigations into their own care.
2. Unit/service/pathway design and management – PSPs at this level might be involved in the training and recruitment of senior staff, other PSPs and procurement. They will also review safety information, hold providers to account and participate in safety investigations not related to their own care.
3. Governance quality/safety oversight – PSPs at this level will be members of safety and quality committees, medicines safety oversight groups, learning from deaths groups, patient safety audits and patient safety improvement projects.
4. Strategy and policy setting – PSPs at this level will work with boards to help them learn from patients' experiences, advise leaders on where PSP input is needed and join national and regional patient safety groups – contributing to patient safety alerts and policy development.

The aim is for all safety-related clinical governance committees in NHS organisations to include two PSPs by April 2021 with training provided by 2022.

Patient safety education and training

To better shape safety education in the NHS, the following measures will be introduced:

- robust, achievable and aspirational plan patient safety training in the NHS
- safety training within professional education programmes to be made explicit and mapped to competencies in the national syllabus
- ensure access to patient safety training for every member of the NHS, from 'ward to board and commissioner to provider'.

These measures will form part of a wider push to create a new patient safety syllabus, potentially looking at five key aspects of safety:

1. System approach to safety
2. Learning from incidents
3. Human factors and safety management
4. Creating safe systems
5. Being sure about safety

Work in this area is ongoing and no hard date for implementation of a new syllabus has been set.

Patient safety specialists (PSS)

PSSs will lead on safety within their organisation, they will be drawn from within the organisation and expected to be in post by around April 2020.

There is scope for further professionalisation of this role, however for the time being it is expected that these roles will be developed in a reactive manner as more is learned about what the role entails.

Key responsibilities include:

- ensuring systems thinking, human factors and just culture principles are embedded in all safety activities
- empowering staff to take responsibility for patient safety in whatever role they undertake
- having oversight for all patient safety activities across their organisation.

Improvement

Continuous improvement and the National Patient Safety Improvement Programme

Following the work of the National Patient Safety Improvement Programme (NPSIP) and patient safety collaboratives over the past five years, four national priorities have been identified:

1. Preventing deterioration and sepsis
2. Medicines safety
3. Maternal and neonatal safety
4. Adoption and spread of tested interventions

Alongside these priorities, the NPSIP has the following objectives for 2020–25:

- continuing to deliver safety improvement in the four current priority areas
- developing an improvement pipeline using national insights and recommendations to inform future improvement work for 2020/21 onwards
- working with 'test' organisations to support adoption and spread
- supporting local engagement across all care settings through structured quality improvement safety initiatives
- continuing to support the conditions for a safety culture to flourish

- building leadership and safety improvement capability across the system
- supporting improvements in the measurement of patient safety and publish the learning from and impact of this programme
- supporting the NHS to learn from both harm and excellence.

Dedicated specialist safety programmes

The strategy also focuses on a number of programmes tasked with improving safety in specific areas:

- maternal and neonatal safety improvement programme
- medicines safety improvement programme
- mental health safety improvement programme
- safety Issues that particularly affect old people
- safety and learning disabilities
- antimicrobial resistance and healthcare associated infections.

The NHS Confederation's response to the strategy

The principles outlined in the strategy are all crucial to the delivery of safer, more effective healthcare for patients and will be imperative in ensuring that NHS staff can speak up without fear of reprisal when they make or witness a mistake.

This strategy sets the right direction of travel for the NHS – seeking to restore the faith of staff and patients in the NHS' ability to respond to mistakes and learn from harm. However, the key to realising this ambition will be ensuring that NHS organisations have sufficient resources and autonomy to deliver it.

Many of the initiatives outlined in the document are sound and necessary. The creation of a medical examiner system to improve learning from deaths, the quality of death certification and the experience of those who have been bereaved is welcome, but any national oversight of this programme must be appropriately balanced with local autonomy in emerging NHS integrated care systems.

In keeping with the government's broader digital strategy for the NHS, an overhaul of the system used to process patient safety reports is set to transform the infrastructure of communication when it comes to safety. However, this will require NHS organisations to improve their information technology systems in line with modern technology standards, something that will likely be expensive and time consuming.

The core message of the strategy – to encourage a culture of learning is both timely and sensible, emphasising the creation of just culture where staff can speak out and reflect on mistakes without fear of reprisals. However, the devil will be in the detail – upcoming measures including the creation of the Health Service Safety Investigations Bill as well as the creation of a regulator for senior managers within the NHS promise to give statutory powers to bodies who will ultimately be tasked with carrying out investigations into breaches of patient safety. With any rebalancing of power, there is always a risk that measures intended to improve safety may hinder it if not introduced in a nuanced way. While malicious or criminally negligent practice must always be appropriately dealt with, we must ensure that faith in the NHS framework for learning from harm is not undermined by bodies who may subsequently draw on this learning to sanction or prompt investigations from national or legal bodies.

This strategy's aim to encourage learning and openness is the right thing to do, but it is important that in bestowing new statutory powers on HSIB (to become HSSIB) and creating a regulator for senior managers in the NHS, these laudable aims are not undermined.

For more details on any of the information outlined in this briefing please contact David Parkin, policy associate at the NHS Confederation: david.parkin@nhsconfed.org



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