Patient Safety is everyone's responsibility: The New Patient Safety Strategy

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Continued improvements in patient safety will reduce unintended or unexpected harm to patients during the provision of healthcare services. The NHS Patient Safety Strategy seeks to ensure improvement in both patient safety and standards. It is estimated that the initiative could save almost 1,000 extra lives and £100 million in care costs each year from 2023/24. It is also considered that there is potential scope to reduce claims provision by around £750 million per year by 2025.

Read more to see how the new Strategy could impact your organisation.

The NHS Patient Safety Strategy

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Aidan Fowler, NHS National Director of Patient Safety, has described the new principles that will underpin the improvement in safety standards in primary care. "***This is not a document written by us telling you what you should do. It is rather a document curated by us on behalf the NHS and is a statement of our collective intent to improve safety by recognising that to make progress, we must significantly improve the way we learn, treat staff and involve patients***"

This patient safety vision will be achieved by developing both a patient safety culture and a patient safety system through three strategic aims:

- **Insight** – to improve understanding of safety by drawing insight from multiple sources of patient safety information;
- **Involvement** – to equip patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system;
- **Improvement** – to design and support programmes that deliver effective and sustainable change in the most important areas

What will each aim look like?

Insight

The aim is to adopt a holistic approach by collating intelligence from multiple sources in order to be accurately informed about avoidable risks and harm which is experienced by patients during the provision of healthcare. **The Patient Safety Incident Response Framework** (PSIRF) will replace the Serious Incident Framework and will support the operation of systems to assist with learning and improvement. It will also allow organisations to examine incidents openly without fear of adverse consequences.

Learning will be enhanced by identifying incidents and undertaking meaningful analysis. The PSIRF proposals will also explore a broader systems approach which is proactive and transparent. The emphasis is placed on a risk-based approach which will allow organisations to develop a patient safety incident review and investigate safety by drawing on a number of resources. The idea is that safety investigations are no longer asked to judge avoidability, predictability, liability, fitness to practice and cause of death.

Steps are also being taken to implement a new **National Patient Safety Alerts Committee** which will improve the response to new and emerging risks and a **Medical Examiner System** comprised of individuals who are employed to independently scrutinise deaths. The objective of this system is to provide an improved service for the bereaved and to ensure that any

issues regarding the quality of care can be identified and then subsequently addressed.

It is intended that the focus on improving understanding, through insight, will help to reduce the number of clinical negligence claims. The early notification scheme for maternity claims, and the Getting It Right First Time programme have already been implemented and further research has been carried out with the aim of improving the NHS's response when things go wrong. The emphasis on a systems approach will complement the schemes already in place, to encourage NHS staff to be open when things go wrong.

The introduction of a system, to replace the **Strategic Executive Information System** (StEIS) and **National Reporting and Learning System** (NRLS), is intended to provide new and wider ranging data collection portals, which will be simpler and easier to use.Triangulation – the alignment of data on incidents, complaints and claims is intended to be key to extracting the necessary insight to achieve the overall vision. **Helen Vernon, Chief Executive of NHS Resolution** has set out her views on the importance of gaining and sharing insight from clinical negligence claims and has confirmed that NHS Resolution will "***continue to support work across government to address the costs of clinical negligence claims - so that more money is available for healthcare - and use the costs and causes of litigation to inform decisions about improvement priorities***"

Involvement

Once again there is a continued emphasis upon the importance of involving patients and their carers/families in improving the quality of NHS care. The aim is for those voices to be heard right up to board level, as patients are able to provide invaluable insight into patient risk issues. This is to be achieved by the creation of **Patient Safety Partners** (PSPs) who will be recruited specifically to participate in service and pathway design, safety governance and strategy and policy. They will receive dedicated training and will be offered remuneration for their work. The aim is for all safety related clinical governance committees, or equivalent, in NHS organisations to include PSPs by April 2021.

There will be a new universal syllabus, applicable to all NHS staff. The report emphasises this is not simply teaching clinicians how to practice safely; that happens already. It is about embedding in all staff that error is normal, it does occur, and what the right approaches are to reduce the risk and maximise the chances of things going well.

Whilst all staff will follow the same syllabus, there will be specialist training modules for Patient Safety Specialists, who will be individuals within the NHS who already have some responsibility for patient safety. Despite the development of these roles the fundamental principle remains that "patient safety is everyone's responsibility – a specialist is not accountable for an organisation's safety on their own".

The NHS is committed to focusing on "Safety II", in other words why things go right, and sharing knowledge and ideas about what works, rather than focusing on when things go wrong ("Safety I"). The importance of conversations and meaningful feedback is emphasised, and staff will be encouraged to report problems via an incident reporting system, without waiting for an incident to happen first.

As part of the whole systems approach to safety, privately-funded healthcare providers will share and integrate data into NHS systems for the first time.

Improvement

The revised **National Patient Safety Improvement Programme** will prove key in embedding the right culture to ensure continuous and sustainable improvement. This identifies priorities in specific areas such as sepsis, preventing deterioration (NEWS2), medicine safety, maternal and neonatal safety, and the adoption and spread of tested interventions.

In addition, there will be focus on specific safety issues, such as mental health, issues that affect older people, patients with learning disabilities and the challenges presented by antimicrobial resistance and healthcare associated infections.

Impact

Time will tell as to whether the New Strategy really does bring a sea of change to the world of Patient Safety. The new processes and systems will require consideration and implementation in order to reap the tangible benefits for your organisation and patient safety as a whole. To understand more about how the New Strategy can be taken forward at your organisation don't hesitate to contact our team of healthcare lawyers who can advise upon how the new system changes will make a difference and how to implement necessary changes.

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