Cambridgeshire Community Services NHS Trust

APPENDIX 1

NHS Patient Safety Strategy 2019 (Safer Culture, Safer Systems, Safer Patients)
Update to Trust Board – March 2022
Liz Webb (Deputy Chief Nurse/Trust's Patient Safety Specialist)

The National Patient Safety Strategy was published in 2019 https://www.england.nhs.uk/patient-safety/the-nhs-patient-safety-strategy/.

It is intended that patient safety is 'a golden thread' running through healthcare. The foundations of the strategy are a patient safety culture and a patient safety system.

There are three strategic aims:

- Improving understanding of safety by drawing intelligence from multiple sources of patient safety information **(Insight)**.
- Equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system **(Involvement)**.
- Designing and supporting programmes that deliver effective and sustainable change in the most important areas **(Improvement)**.

Insight

The NHS will:

- Adopt and promote key safety measurement principles and use culture metrics to better understand how safe care is.
- Use new digital technologies to support learning from what does and does not go well, by replacing the National Reporting and Learning System with a new safety learning system.
- Introduce the Patient Safety Incident Response Framework to improve the response to an investigation of incidents.
- Implement a new medical examiner system to scrutinise deaths.
- Improve the response to new and emerging risks, supported by the new National Patient Safety Alerts Committee.
- Share insight from litigation to prevent harm.

Involvement

The NHS will:

- Establish principles and expectations for the involvement of patients, families, carers and other lay people in providing safer care.
- Create the first system-wide and consistent patient safety syllabus, training and education framework for the NHS.
- Establish patient safety specialists to lead safety improvement across the system.
- Ensure people are equipped to learn from what goes well as well as to respond appropriately to things going wrong.
- Ensure the whole healthcare system is involved in the safety agenda.

Improvement

The NHS will:

- Deliver the National Patient Safety Improvement Programme, building on the existing focus on preventing avoidable deterioration and adopting and spreading safety interventions.

- Deliver the Maternity and Neonatal Safety Improvement Programme to support reduction in stillbirth, neonatal and maternal death and neonatal asphyxial brain injury by 50% by 2025.
- Develop the Medicines Safety Improvement Programme to increase the safety of those areas of medication use currently considered highest risk.
- Deliver a Mental Health Safety Improvement Programme to tackle priority areas, including restrictive practice and sexual safety.
- Work with partners across the NHS to support safety improvement in priority areas such as the safety of older people, the safety of those with learning disabilities and the continuing threat of antimicrobial resistance.
- Work to ensure research and innovation support safety improvement.

What does this mean to us?
In a letter (https://www.sfh-tr.nhs.uk/media/12473/enc-082-appendix-1-210826-patient-safety-specialists-letter.pdf), trust boards are asked to adopt the strategy and lead on its implementation throughout the organisation. Identify a board level lead for Patient Safety and the implementation of the strategy. Annually a Patient Safety Response Plan will be signed off by the board, agreeing the focus for investigations that mean quality of investigation over quantity, and look at systemwide improvement. For us this will mean more participation with ICSs and other partners for investigation rather than in isolation.

As a Trust, this strategy is woven through the Clinical and Quality Strategy, and work started pre-Covid to integrate with the People Strategy, which is obviously key. Similarly, the need to embrace quality improvement (QI) methods from floor to board integrating the work of service redesign and the clinical quality portfolios. Some of the changes are simple to make, whilst others, such as mandatory safety training and the revised framework for investigating safety incidents, are much more complex.

Work has started across all the elements of the strategy; these are detailed below with a short progress update.

CCS NHS Trust progress against key priorities for NHS Patient Safety Strategy

Patient Safety Strategy requirement of all trusts	Progress to date
Board insight NHS England » The NHS Patient Safety Strategy	https://www.sfh-tr.nhs.uk/media/12473/enc-082-appendix-1-210826-patient-safety-specialists-letter.pdf
Equality, diversity, and inclusion A commitment to address patient safety inequalities, including LeDER; pressure ulcers.	David Vickers, Executive Director for Health Inequalities Attend the BLMK LeDER reviews Learning from Deaths Group Pressure Ulcer – Stop the pressure – continues including benchmarking project with ELFT. Equality, Inclusion and Diversity (patient facing) post is being advertised Increase in Adult Safeguarding provision has meant that a lead for LeDER has been identified
Patient safety infrastructure • Development of regional and local networks • Appointment of a patient safety specialist • Focus on safety culture and safe systems	Liz Webb is the Trust's Patient Safety Specialist and links into the local, regional and national networks.
Just culture Embed the principles of a safety culture on an ongoing basis. These should include monitoring and response to NHS staff survey results and any other safety culture assessments, adoption of the NHS England and NHS Improvement 'A Just Culture Guide' or equivalent.	Clinical and HR policies and procedures take a Just Culture approach. We review the NHS staff survey results and have agreed actions to improve patient safety culture. Freedom to Speak Up outcome continues to be positive – however the outcomes are reviewed, and work is ongoing.

Patient Safety Strategy requirement of all trusts	Progress to date
National Patient Safety Alerts An Alert was issued by the Central Alerting System (CAS) helpdesk in September 2019 (CHT/2019/001: The introduction of National Patient Safety Alerts) which set out actions for NHS organisations to support the introduction of the new NatPSAs: • Identify appropriate escalation routes for National Patient Safety Alerts to ensure organisation-wide coordination and senior oversight. • Note the dual running period and action all alerts in the appropriate manner. • Embed process for ensuring senior oversight and actioning of NatPSAs within your internal SOPs. There is an existing contractual and regulatory requirement to complete actions required in NatPSAs and this is reinforced by the strategy requirement that '100% compliance declared for NatPSAs by their action complete deadlines'.	DATIX is used as the system for the receipt and actioning of NatPSAs. Kate Howard and David Vickers are the executives informed of these and the cascade and management of the process is led by the Incident, Risk and Safety Manager, overseen by Liz Webb DCN/PSS. All NPSA alerts are now reported to board for oversight.
Improving quality of patient safety incident reporting	Work in progress, Safety team work directly with staff on content and quality.
Support transition from NRLS and STEIS to Learn from patient safety events service (LFPSE)	Datix will link to the new LFPSE system. Communication in due course.
Implement the Framework for Involving Patients in Patient Safety Trust to include two Patient Safety Partners on safety related clinical governance committees (or equivalent) by July 2022 and elsewhere as appropriate.	Role description and preparation for advert underway. New Deputy Clinical Quality Manager has this in their workplan. Policy for supporting payment for patient safety partners and patients who choose to be part of the Trusts coproduction programme is in its final draft

Patient Safety Strategy requirement of all trusts	Progress to date
Patient safety education and training Support all staff to receive training in the foundations of patient safety by April 2023. https://www.hee.nhs.uk/our-work/patient-safety **National patient safety syllabus** **Training for every member of staff across the NHS Making Safety Active:** • Preventing harm before it occurs • Seeing risks and making them safe • It's time to change what we do	This is mandated and requires all staff 'Floor to Board' to undertake. **Currently out for consultation**. Not progressed so far. 1. Level 1 (Essentials) Patient Safety Syllabus educational materials are currently being developed for ALL staff. These consist of: • Essentials introductory video (all staff) • Essentials e-learning educational module (all staff) • Essentials e-learning module for Boards and Senior Leadership teams 2. Level 2 (Access to Practice) e-learning educational module for those who wish to progress further, in autumn 2021. 3. Levels 3-5 educational modules.
Implement the new Patient Safety Incident Response Framework (PSIRF) This framework will replace the current Serious Incident framework and documentation.	The Safety Manager and Patient Experience Manager have attended training on the new framework. Clinical Quality Manager and newly appointed Deputy Clinical Safety Manager will develop a project plan and education programme to roll this out. This is a significant change for the whole NHS. National messaging currently is do it incrementally and in step with local ICSs.
National Patient Safety Improvement Programmes • Managing Deterioration Safety Improvement Programme (ManDetSIP) • Maternity and Neonatal Safety Improvement Programme (MatNeoSIP) • Medicines Safety Improvement Programme (MedSIP) • Adoption and Spread Safety Improvement Programme (A&S-SIP) • Mental Health Safety Improvement Programme (MH-SIP)	As a trust we will participate as appropriate, particularly around Medicines and Managing Deteriorating patients.

Patient Safety Strategy requirement of all trusts	Progress to date
Research **Themes** • Reducing inequalities in healthcare safety. • Improving patient safety intelligence and understanding patient safety challenges. • Improving organisational patient safety culture and practice. • Patient safety behaviours. • Effective patient safety practices. • Patient safety impacts of alternative service delivery models. • Ergonomics, design, and human factors. • Clinical risk scores (validation, implementation, and outcomes).	Research team will explore opportunities to link with studies in due course.

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