# HEALTHCARE LIABILITY

## LEADERSHIP & INNOVATION

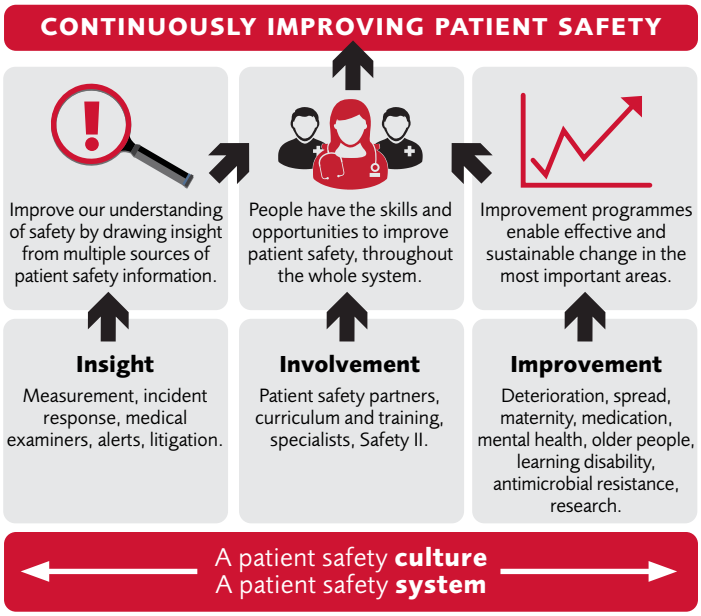
# The NHS Patient Safety Strategy

## Safer culture, safer systems, safer patients

**Research from 2015 suggests that the NHS could fail to save 11,000 lives a year due to safety concerns, with the cost of the extra treatment required following incidents costing at least £1bn.**[1,2]

NHS England and NHS Improvement compiled the NHS Patient Safety Strategy[3], outlining the importance of learning methodology, staff treatment and patient involvement to improve patient safety.[1] This article provides a short summary of some of the key areas of focus.

### Summary of the NHS Patient Safety Strategy




*Source:* The NHS Patient Safety Strategy, July 2019.

### Features of a patient safety culture

The National Clinical Advisor to the Culture, Leadership and Engagement Project offered an illustration of a patient safety culture. There is an emphasis on the fair treatment of staff when incidents occur; on the benefits of having a diverse workforce; on the importance of strategy and ambition for the team; on compassionate leadership and a culture of learning rather than punishment.

Psychological Safety for Staff • Leadership & Teamwork
Diversity • Open to Learning • Compelling vision

### Digital and technology

Technological advancement has the potential to offer new solutions for improvements in patient safety. Systems can benefit patients by ensuring that staff members have complete and accurate records that are kept up to date. The strategy also recommends the full use of electronic records, for example, by the prospective recording of treatments, the procedure, devices and medications. Scan4Safety adopted this approach successfully.[4]

### Insight from clinical negligence claims

Claims information can be useful in revealing system-wide issues that can lead to harm. Recommendations in the strategy include encouraging early notification of incidents, using scorecards to help target interventions better, research into causes of incidents and sharing the learning outcomes.

The Getting It Right First Time 'GIRFT' programme was launched in 2012 in order to standardise care and improve efficiency in orthopaedic departments across NHS trusts in England. A senior clinician visited NHS hospitals with data from national datasets, audits and registries. It has published best practice guidance based on claims learning in orthopaedic surgery, focussing on hip and knee arthroplasties.

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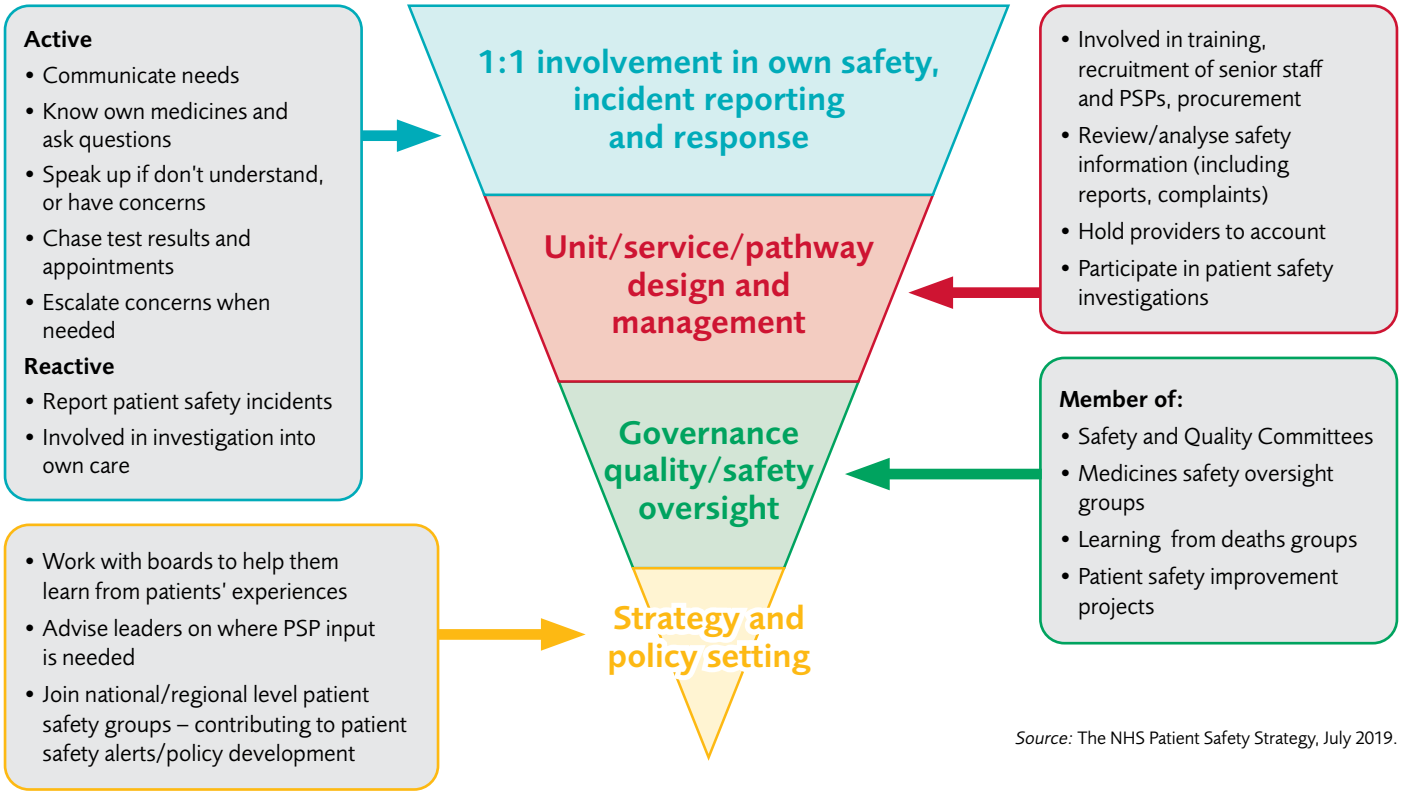
## Patient safety partners (PSPs)

Patients, families, carers and other lay people are key in delivering the patient safety strategy. These partners, each with a clear and defined role, should be involved in service and pathway design, safety governance and strategy and policy.

## Potential roles of patient safety partners




*Source:* The NHS Patient Safety Strategy, July 2019.

## Patient safety syllabus

The NHS is collaborating with a number of partners in order to broaden and deepen training so that every member of staff has access to standardised patient safety resources. The aim of the training is to inform all staff, irrespective of role within the team, of the approaches to reduce risk and increase chances of providing safe care. The below diagram represents proposed modules for a patient safety syllabus from the Academy of Medical Royal Colleges.

## Potential modules for a national patient safety syllabus
(from the Academy of Medical Royal colleges patient safety syllabus)


*Source:* The NHS Patient Safety Strategy, July 2019.

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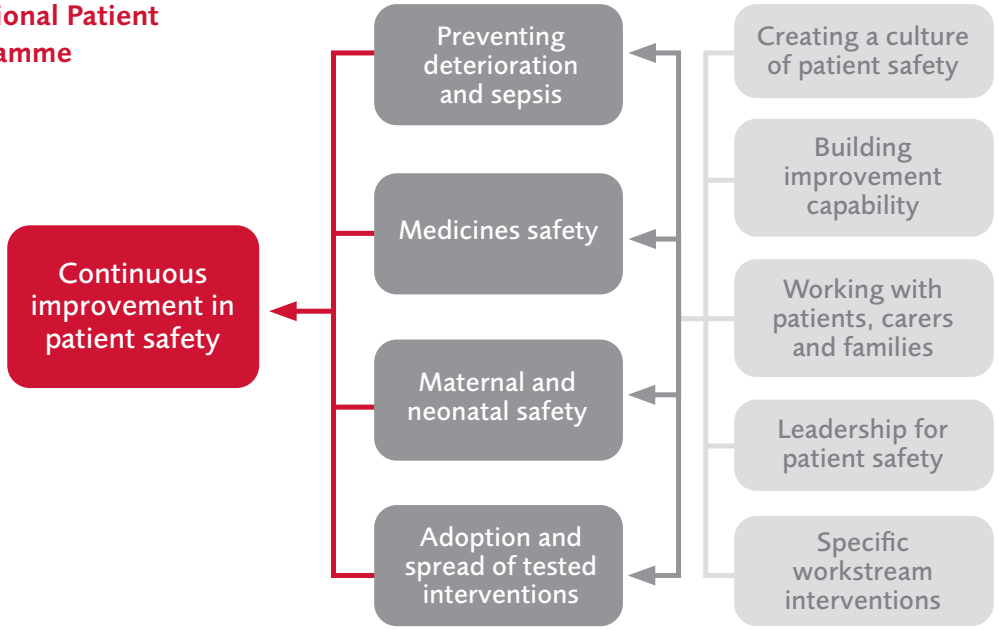
## Preventing deterioration and sepsis

There is a national focus to improve the detection and treatment of a deteriorating patient. The focus is on three areas: recognition, response and reliable escalation. The adoption of NEWS 2, which is a system to standardise the assessment and response to acute illness, in acute services and ambulances across England provides a good starting point for this.[5]

## Driver diagram for the National Patient Safety Improvement Programme




*Source:* The NHS Patient Safety Strategy, July 2019.

## Conclusion

NHS England and NHS Improvement have made a significant step in compiling this strategy to demonstrate its commitment to improving patient safety. It lists a number of clinical priorities, including improving the detection of sepsis, maternity care and medications management. In addition, the strategy comments on the combination approach of Safety I and Safety II, emphasising the importance of reviewing the steps taken to provide safe care, whilst also reviewing the errors when harm has occurred. It is clear that this strategy will undergo continuous adaptation and it will provide a foundation for continuous improvement of patient safety in the NHS.

## Sources and further reading

1. Hogan et al. (2015). Avoidability of hospital deaths and association with hospital-wide mortality ratios: retrospective case record review and regression analysis. BMJ 351: h3239.
2. Hogan et al. (2012). Preventable deaths due to problems in care in English acute hospitals: a retrospective case record review study. BMJ Qual Saf 21(9)
3. The NHS Patient Safety Strategy, July 2019. https://improvement.nhs.uk/resources/patient-safety-strategy/ accessed 25/07/2019
4. https://www.scan4safety.nhs.uk/ accessed 25/07/2019
5. https://www.england.nhs.uk/ourwork/clinical-policy/sepsis/nationalearly-warningscore/ accessed 25/07/2019