South West London
Clinical Commissioning Group

National Patient Safety Strategy
Briefing for SWL CCG Non-NHS Providers

The National Patient Strategy

The National Patient Safety strategy was released in July 2019 and updated in February 2021.

It acknowledges that patient safety has made great progress but there is much more to do. Some of the work that still needs to be done include.

- knowing enough about how the interplay of normal human behaviour and systems determines patient safety.
- The mistaken belief persists that patient safety is about individual effort.
- People often fear blame and close ranks, losing sight of the need to improve.
- Needing to do more to share safety insight and empower people, patients and staff with the skills, confidence, and mechanisms to improve safety.

To address these challenges will enable the NHS to achieve its safety vision**; to continuously improve patient safety**. To do this, need to build on two foundations: **a patient safety culture** and **a patient safety system**. Three strategic aims will support the development of both:

- 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 initiatives

- **Patient Safety Incident Management System (PSIMS)** is a new digital system to support patient safety learning that will replace the National Reporting and Learning System (NRLS) and Strategic Executive Information System (STEIS). Vision for PSIMS is to have one single port of call for recording, accessing, sharing, and learning from patient safety incidents of NHS-funded services at all levels of the health system. Current national timetable is that they are expecting all organisations (including non-NHS organisations we commission from) to connect to the new system by end Q4 2021/22. The national team patient safety team has provided detailed information to explain about PSIMS and how your organisation can engage and implement what is required. This information can be found here . The CCG is encouraging all our providers to start to engage using this system in line with national guidance.

- **Patient Safety Incident Response Framework (PSIRF)** is being introduced to improve the response and investigation of incidents. This will replace the current Serious Incident Framework (2015). An 'Introductory version of the PSIRF was released March 2020, this is being piloted by a few early adopters across the country. Feedback from these pilots will inform the final version of the framework that will be rolled out to all organisations by Q1 2022/23. All organisations are being asked to start familiarising themselves with draft framework and progress of events to

publication of the final version. CCG will engage with providers as we plan our road map to the rollout. Details of PSIRF, introductory framework, national timetable and progress can be found here.

- **Medical Examiner (ME)** is a new system that has been rolled-out across England and Wales to provide independent scrutiny of the deaths, offer a point of contact for bereaved families to raise concerns about the care provided prior to the death of a loved one. All/Most Acute trusts in England have now set this up. There are plans for further roll out for scrutiny of all community deaths. There will be some involvement with this process with all our providers, and we are encouraging you all to be aware of progress and changes. Detailed information on the medical examiner system, progress so far, and changes are available here.

- **National Patient Safety Alerting Committee (NaPSAC) and National Patient Safety Alerts (NatPSA)**: Changes are being implemented to the way national organisations develop and issue safety alerts to healthcare providers through the introduction of National Patient Safety Alerts. The NaPSAC is developing common standards and thresholds that can be followed by all safety alert issuing organisations so we have a single format for alerts which will make it much easier for local systems to see what they need to do, by when and why. The standards and thresholds agreed by NaPSAC will underpin CQC's inspection of National Patient Safety Alerts and any regulatory response to non-compliance. All healthcare providers will be required to introduce new systems for planning and coordinating the actions required by any National Patient Safety Alert across their organisation and must include executive oversight. The CCG is asking all our providers to review and ensure this is implemented and embedded in your organisations. For more detail on the changes and what organisations are expected to implement please visit the national site here.

Involvement Initiatives

- **Patient Safety Specialist**: Large NHS organisation were asked to nominate a patient safety specialist (PSS) by Nov 2020. For all our Non- NHS organisations, at this current time are not required to identify your own PSS however can designate a PSS if able to do so or consider accessing appropriate input from a PSS working across multiple organisations or part time. More information on what the role entails and wat you may need to do should you wish to at this time or when it does become a requirement for your organisation , can be found here

- **Involving Patients in Safety**: A framework for involving patients is being developed. The consultation completed in Oct 2020 and we are expecting the final version to be released by April 2021. All organisations will be required to implement the guidance in the new framework when it is released. More detail on the framework and the national work can be found here.

- **Patient Safety Training**: The national patient safety team and HEE are creating the first system-wide patient safety syllabus, training, and education framework for the NHS. It is anticipated that the first levels of the training that will be for all staff will be ready from July 2021 approx. All our providers will be expected to engage with the patient safety training when its launched as required. Details of the training being planned and progress of events until launch are available here

- **Safety I and Safety II**: The need to widen patient safety thinking beyond a focus on the rare examples of things going wrong ('Safety I') to why things routinely go right in healthcare ('Safety II') is now a strong emphasis. Organisations are being encouraged to continuously explore how to give people the skills to take a Safety II approach without losing their focus on Safety I and builds this as part of the culture. The national team will embed training in learning from what goes well alongside other prospective safety improvement techniques in the new national patient safety syllabus and the Safety II principles are also being embedded in PSIMS.

Improvement Initiatives

There are several national patient safety improvement programmes that are outlined in the national strategy. There is / will be engagement with non-NHS providers in these areas. Details of the programmes is also available here

There are other initiatives not detailed above that are being implemented as outlined in the strategy to include improving how we measure safety; enhancing learning from litigation; Improving the alignment between NHS and independent sector healthcare. Providers are encouraged to engage with these and be aware as detailed on the national website and in the strategy. CCG will continue to work and support you all as we all continue to work towards enhancing and improving our approach to patient safety across South West London

Note: *Timelines indicated above are as of Feb 2021, there may be some changes to this due to current changing environment. The changes will be made available on the links provides and national website*

Contact the team

If you have any queries, please contact Charity Mutiti, SWL CCG Patient Safety Specialist on Charity.Mutiti@swlondon.nhs.uk .