A new long-term patient safety strategy for the NHS in England and the place of the PSCs

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NHS England and NHS Improvement
ALMOST EVERY SUCCESSFUL PERSON BEGINS WITH TWO BELIEFS: THE FUTURE CAN BE BETTER THAN THE PRESENT, AND I HAVE THE POWER TO MAKE IT SO.

DR. SEUSS
Estimated annual cost of patient safety incidents in the NHS

11,000 lives

Based on Hogan et al 2015 study and NRLS data
Estimated annual cost of patient safety incidents in the NHS

£1 bn
in extra treatment

The costs of the extra treatment needed following patient safety incidents is estimated at £1 billion or more.
Estimated annual cost of patient safety incidents in the NHS

£2.2 bn in litigation

Between 06/07 and 17/18, clinical claims payments have quadrupled, from £0.4 billion to £2.2 billion.
Launched 2 July 2019 – the NHS Patient Safety Strategy

Safer culture, Safer systems, Safer patients
The NHS will:

- adopt and promote **key safety measurement principles** and use **culture metrics** to better measure how safe it 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, and 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.
National Patient Safety Alerts

- All alerts will be National Patient Safety Alerts using the same template, no matter which organisation is the issuer.

- Each alerting body to go through the process of accreditation against the thresholds and criteria agreed by NaPSAC to ensure they meet the requirements. Dual running for next 12 months.

- Alerts will have clear and effective actions that providers must take on safety-critical issues.

Bodies accredited to date:

- NHS Improvement Patient Safety Team – accredited for three years from July 2019.
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 curriculum, 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.
Patient Safety Syllabus

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

- Systems approach to patient safety
- Learning from incidents
- Human factors and safety management
- Creating safe systems
- Being sure about safety
The Hierarchy of Intervention Effectiveness

- Forcing Functions
- Automation & Computerization
- Simplification & Standardization
- Reminders, Checklists & Double Checks
- Rules & Policies
- Education & Training

MORE EFFECTIVE

LESS EFFECTIVE

System-focused

People-focused
Improvement

The NHS will:
• deliver the **National Patient Safety Improvement Programme**
• deliver the **Maternity and Neonatal Safety Improvement Programme**
• develop the **Medicines Safety Improvement Programme**
• deliver a **Mental Health Safety Improvement Programme**
• continue efforts to prevent **falls, pressure ulcers, venous thromboembolism and healthcare-associated infection**
• support safety improvement in priority areas such as **safety of older people**, safety of those with **learning disabilities** and the continuing threat of **AMR**.
Scale for improvement

• 15 regional-based patient safety collaboratives with a population footprint of 2-5 million

• Primary focus on testing safer care pathways and interventions, adoption and national scale-up

• Requirement for a better definition of the problem(s) being addressed at regional and national level

• Defining the potential benefits of an intervention

• Understanding how a local improvement can be implemented nationally
Current PSC ask

- Managing Deterioration: improving the recognition, response and escalation pathway, including support for the adoption of NEWS2 across care settings
- Medicines Safety: reducing harm as a result of errors in the administration of medicines in care homes
- Maternity and Neonatal Safety: developing local learning systems to support the national ambition
- Adoption and Spread: supporting the adoption and spread across England for:
  - PreCept
  - Emergency laparotomy bundle
  - ED checklist
  - COPD discharge bundle
Future Improvement Programme Structure

Patient Safety Improvement

- National Patient Safety Improvement Programme (NatPatSIP)
- Maternity and Neonatal Safety Improvement Programme (MatNeoSIP)
- Medicines Safety Improvement Programme (MedSIP)
- Mental Health Safety Improvement Programme (MHSIP)
- Care Homes Safety Improvement Programme (TBC)

Deterioration Management

Spread and Adoption / Innovation

2019/20: national programme delivery via 15 regionally-based Patient Safety Collaboratives (PSCs)

Proposed for 2020/21 onwards
PSCs have a key role in the delivery of patient safety improvement and innovation and to support:

- The ambition of all national safety improvement programmes
- The specific safety needs of regional and local populations through a number of locally determined priorities, including partnership working with patients and families
- Pathway redesign and engagement across all care settings
- New delivery models that are cost-effective and a consistent approach to targeted capability building and systematic quality improvement
- The prioritisation of evidence-based interventions amenable to national scale-up
- A more robust measurement system that both steers programmes of work and demonstrates clear improvement impact
- A comprehensive ‘learning system’ across the NHS in order to effectively share improvement lessons
New programmes – Mental Health

Overview:

• Two strands of work have to date focussed on Trust Engagement and Reducing Restrictive Practice.
• Sexual Safety Collaborative due to commence October 2019
• Interim programme review of current work underway

Proposed 2020/21 priorities:

• Reducing restrictive practice
• Sexual safety
• Prevention of suicide and self-harm in inpatients (to include offender health)
• Long term antipsychotics and obesity
New Programmes – Medicine Safety

Overview:
• An estimated 237 million medication errors occur in England every year, 66 million of which have clinical impact
• The third WHO Global Patient Safety Challenge: Medication Without Harm aims to reduce severe avoidable medication-related harm by 50%, globally by 2022
• Work on reducing harm as a result of errors in the administration of medicines in care homes commenced Oct 2019
• Programme design currently underway to inform key priority areas

Initial Programme Proposals:
• Anticoagulation transition
• Drug administration in care homes
• Shared decision making pharmacist training to work with people with Atrial Fibrillation
• Better shared decision making with patients on opioids
• Structured Medicines Reviews across an integrated system starting with patients at risk due to polypharmacy
New opportunities for PSCs

• Building on the care home work in deterioration and medicines safety, the development of a national care home safety improvement programme
• Capability building
• A greater focus on innovation?
• Development of an ‘improvement pipeline’
• A single NHSE and NHSI commission and contract from 2020/20 with a streamlined assurance process
• Improved links with regional teams to support work
• Better improvement measures to demonstrate impact
Cost and impact

• Current national delivery envelope for 2019/20 = £7m
• The cost per national programme will be defined to aid appropriate funding of PSC delivery activity for 2020/21 onwards
• The PSCs have established structures, processes and networks that provide the opportunity to drive patient safety improvement work across the country, backed by the enormous commitment and goodwill of those involved to date
• A more data-driven approach to problem definition and prioritisation of work will help reveal where improvement is required - allowing PSCs to focus their capacity on areas that will have greatest impact
• A streamlined measurement approach for each programme
• Look to expand capacity and support?
If we get this right....

While continuously improving means there is no ‘target’ to achieve, the impact of doing so can be estimated:

- **Better incident reporting and response** could save an extra **160 lives and £13.5 million**.

- If **boosting patient safety understanding and capability** reduces harm by a modest 2%, an extra **200 lives and £20 million** could be saved.

- Focusing **improvement programmes** on those areas where most harm is seen could save **568 lives and £65 million**.

- **This adds up to 928 lives saved and £98.5 million** more available for care per year. It is not possible to quantify all the potential benefits, so this impact will likely be greater.

- We think it is reasonable to expect to see this level of impact from **2023/24** onwards.

- In addition, the potential exists to **reduce the claims provision** related to neonatal brain damage incidents by around **£750m per year** by 2025 (based on current prices).
…..we could save

1,000 extra lives
and £100m

every year from 2023/24
excluding litigation costs
Thank you for listening

improvement.nhs.uk/resources/patient-safety-strategy/