Bradford Teaching Hospitals
NHS Foundation Trust

NHS Patient Safety Strategy

Safer culture, safer systems, safer patients

July 2019

An Overview

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The **NHS Patient Safety Strategy** recognises our patient safety journey from talking about harm to talking about systems which provide the right care, as intended, every time, and learning from what works, not just what does not……

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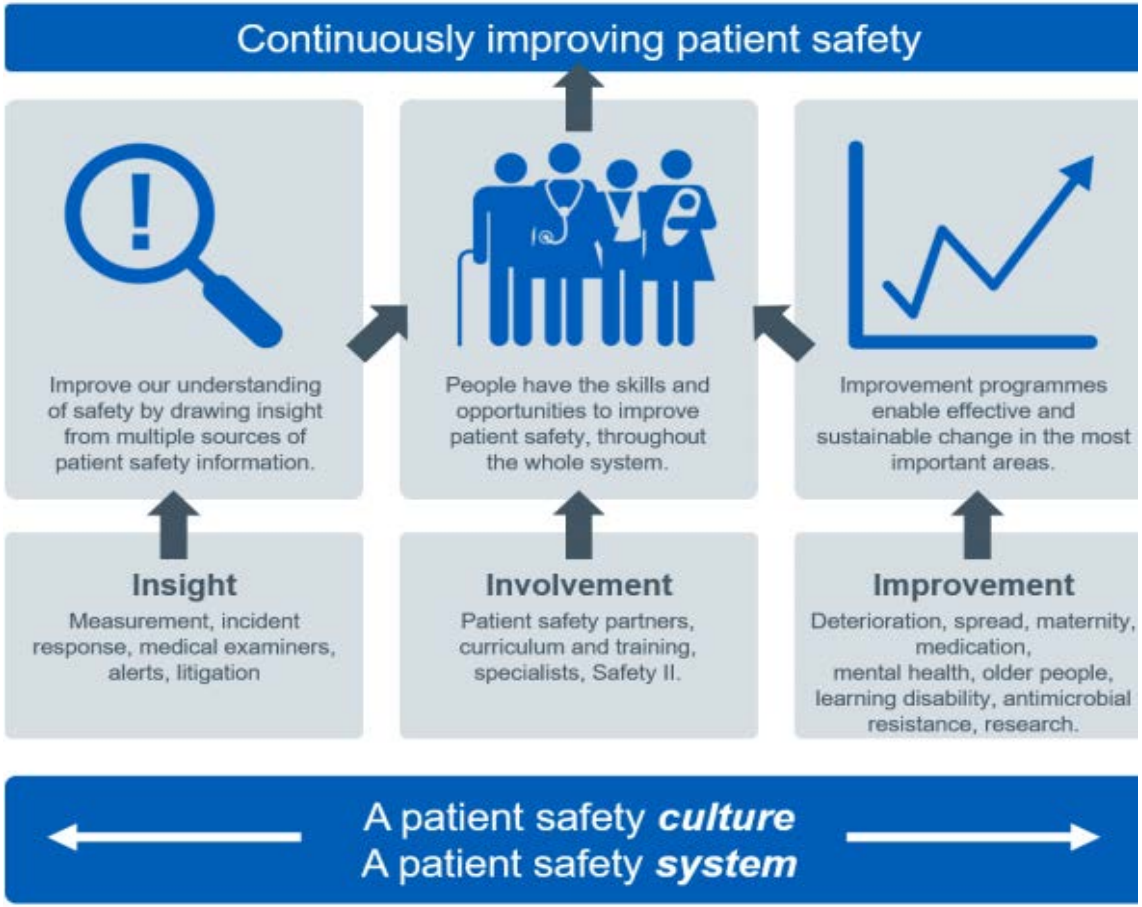
The opportunity is huge. Hogan et al's research from 2015 suggests we may fail to save around 11,000 lives a year due to safety concerns, with older patients the most affected. The extra treatment needed following incidents may cost at least £1 billion.

Hogan et al (2015) using 2009 and 2012/13 data adjusted to include A&E, outpatients, day surgery. Adjustment uses ratio of inpatient to other deaths from incident reporting data

…..It 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.

To do this the NHS will build on two foundations: **a patient safety culture** and a **patient safety system** supported by 3 strategic aims……..



…..we have reviewed the strategy, incorporated its requirements into our Quality Plan and will monitor our delivery through the Patient Safety Sub-Committee...

'Insight' work aims to improve understanding of safety across the whole system by drawing intelligence from multiple sources of patient safety information…….

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- Measurement
- A new digital system to support patient safety learning
- The Patient Safety Incident Response Framework
- The Healthcare Safety Investigation Branch (HSIB)
- The medical examiner system
- National clinical review and response
- The National Patient Safety Alerts Committee
- Clinical negligence and litigation (incl GIRFT)

'Involvement' work aims to ensure that patients, staff and our partners have the skills and opportunities to improve patient safety…….

- Patients, carers, families and lay people as partners
- Patient safety education and training
- Patient safety specialists
- Safety I and Safety II
- Independent sector

'Improvement' work aims to develop and support safety improvement programmes that prioritise the most important safety issues and employ consistent measurement and effective improvement methods.

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- Continuous improvement
- The National Patient Safety Improvement Programme

Focusing on…

- Sepsis
- Medicines
- Maternal and neonatal safety
- Adoption and spread of tested interventions

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Specific national programmes

- The Maternity and Neonatal Safety Improvement Programme
- The Medicines Safety Improvement Programme
- The Mental Health Safety Improvement Programme
- Safety issues that particularly affect older people
- Safety and learning disabilities
- Antimicrobial resistance and healthcare-associated infections
- Research and innovation

Summary

- National strategy is further evolution to previous patient safety strategies.
- Delivery over next 2 years.
- Focuses on effective
  - Learning (Trust/Local/Regional and National).
  - Measurement and monitoring for improvement.
  - Broader Involvement (staff/patient/system-wide).
- Trust has a knowledge and expertise to deliver. In part it has many systems/processes and a level of resource to deliver.
- Detailed gap analysis and full delivery plan to be evaluated and report back in 3 months.