

Meeting Title	Board of Directors		
Date	29 September 2021	Agenda item	Bo.9.21.17

NHS PATIENT SAFETY STRATEGY - PATIENT SAFETY SPECIALISTS

Presented by	Karen Dawber Chief Nurse		
Author	Judith Connor Associate Director of Quality		
Lead Director	Karen Dawber Chief Nurse		
Purpose of the paper	This paper will provide the Board with an overview of future arrangements for the monitoring of progress against the 9 key priorities identified within the NHS Patient Safety Strategy, the identified Executive Lead and proposed change to the current Quality Academy to reflect the Trusts commitment to continuous improvement and specifically improving patient safety.		
Key control			
Action required	For approval		
Previously discussed at/ informed by			
Previously approved at:	Academy/Group	Date	
	Executive Team Meeting – E.9(2).21.17	13.09.21	
Key Options, Issues and Risks			
<p>The NHS Patient Safety Strategy was first published in July 2019. This was updated in February 2021 to reflect the evolving healthcare landscape and highlighted those activities which will have the greatest impact on safety improvement. As the Trust’s Academy structure is becoming embedded it is apparent that the Quality Academy’s oversight of improvement and learning also needs to be aligned to the 9 priorities as set out in the NHS Patient Safety Strategy. Alongside this the evolving role of the Patient Safety Specialist is a key role in supporting the organisation in achieving these priorities whilst demonstrating impact on continuous improvement of services and quality of care.</p>			
Analysis			
<p>The Quality Academy being re-named as the Quality and Patient Safety Academy will demonstrate the Trusts commitment to achieving the national priorities as set out in the NHS Patient Safety Strategy without detracting from the wider quality agenda.</p> <p>Future monitoring of the progress and achievement of these priorities will be monitored through the Quality and Patient Safety Academy.</p> <p>Moving from four named Patient Safety Specialists to having one fulltime dedicated Patient Safety Specialist will enable the Trust to realise and embed the improvements associated with the NHS National Patient Safety Strategy as well as support the Trusts ambition to be an outstanding healthcare provider.</p>			
Recommendation			
<p>1. The Board recognises the Chief Medical Officer as the lead executive for the implementation of the NHS Patient Safety Strategy.</p> <p>2. The Board agree and approve the change in the Quality Academy to Quality and Patient Safety</p>			

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Academy.

3. The Board to acknowledge the appointment of a full time standalone Patient Safety Specialist role.
4. The Board agree for current Patient Safety Specialists to present to the Board of Directors at a future meeting.

Risk assessment						
Strategic Objective	Appetite (G)					
	Avoid	Minimal	Cautious	Open	Seek	Mature
To provide outstanding care for patients			g			
To deliver our financial plan and key performance targets			g			
To be in the top 20% of NHS employers					g	
To be a continually learning organisation				g		
To collaborate effectively with local and regional partners					g	
The level of risk against each objective should be indicated. Where more than one option is available the level of risk of each option against each element should be indicated by numbering each option and showing numbers in the boxes.	Low		Moderate	High	Significant	
	Risk (*)					
Explanation of variance from Board of Directors Agreed General risk appetite (G)						

Benchmarking implications (see section 4 for details)	Yes	No	N/A
Is there Model Hospital data relevant to the content of this paper?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Is there any other national benchmarking data relevant to the content of this paper?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Is the Trust an outlier (positive or negative) for any benchmarking data relevant to the content of this paper?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Risk Implications (see section 5 for details)	Yes	No
Corporate Risk register and/or Board Assurance Framework Amendments	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Quality implications	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Resource implications	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Legal/regulatory implications	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Diversity and Inclusion implications	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Performance Implications	<input checked="" type="checkbox"/>	<input type="checkbox"/>

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Regulation, Legislation and Compliance relevance
NHS Improvement: (please tick those that are relevant) <input checked="" type="checkbox"/> Risk Assessment Framework <input checked="" type="checkbox"/> Quality Governance Framework <input type="checkbox"/> Code of Governance <input type="checkbox"/> Annual Reporting Manual
Care Quality Commission Domain: Well Led
Care Quality Commission Fundamental Standard: Safety
NHS Improvement Effective Use of Resources: Clinical Services
Other (please state):

Relevance to other Board of Director's academies: (please select all that apply)			
People	Quality	Finance & Performance	Other (please state)
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

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1 PURPOSE/ AIM

This paper is to provide the Board with an overview of future arrangements for the monitoring of progress against the 9 key priorities identified within the NHS Patient Safety Strategy, the identified Executive Lead and proposed change to the current Quality Academy to reflect the Trusts commitment to continuous improvement and specifically improving patient safety.

2 BACKGROUND/CONTEXT

The NHS patient safety strategy was first published in July 2019. This was updated in February 2021 to reflect the evolving healthcare landscape and highlighted those activities which will have the greatest impact on safety improvement. Whilst the deliverables identified within the strategy have largely unchanged a new objective was added in February 2021 highlighting the work required to reduce health inequalities and disparities in healthcare outcomes which have been amplified as a result of the COVID-19 pandemic.

Within the strategy it was recognised that in order to support and lead the delivery of the strategy a designated role within NHS healthcare providers would need to be established. Initial thoughts were that this role would be akin to that of the Caldicott Guardian or Freedom to Speak Up Guardian but as the deliverables within the strategy have evolved this concept has also evolved. There is now recognition that an individual working full time on this agenda with a nationally standardised job description will enable and facilitate healthcare providers to focus on the priorities and deliver at pace.

When the role was first introduced in 2020 the decision was made by the Chief Medical Officer and Chief Nurse that this role would be shared between four individuals:

Assistant Chief Nurse: Quality and Workforce.
Deputy Medical Director: Quality.
Lead Allied Health Professional, (added in November 2020).
Associate Director for Quality, (added in February 2021).

The intention is that the Patient Safety Specialist (PSS) role will be the lead patient safety expert in their own organisations working full time on patient safety. The role will provide leadership, visibility and expert support to the patient safety work within their organisation. They will support the development of a patient safety culture and safety systems, and the local implementation of the national NHS Patient Safety Strategy. They have a key role in supporting the Trusts executive team to understand the most effective approaches to improving patient safety and ensuring that any patient safety related responsibilities held by different executives are effectively aligned.

Patient Safety Specialists lead, and directly support patient safety improvement activity and ensure that systems thinking, human factors understanding and just culture principles are embedded in all patient safety processes. They also work in networks to share good practice and learn from each other.

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3	PROPOSAL
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Over the last 5 months as the activities associated with this role have become more defined it has become apparent that to fully focus on the realisation and embedding of the priorities within the NHS Patient Safety Strategy this requires one individual to lead this work with continued support from the roles identified above.

It was agreed by executives in August 2021 following a presentation by the current PSSs that a fulltime standalone role will be supported and funded. By formally recognising this as a senior standalone role, who will be fully trained in the national patient safety syllabus demonstrates the organisations commitment to patient safety and quality.

The identified lead executive will be the Chief Medical Officer but it is also acknowledged that this is a shared agenda across all executives.

There are nine key work programmes within the NHS Patient Safety Strategy with associated actions and timescales where appropriate.

These are:

1. Just Culture.
2. National Patient Safety Alerts.
3. Improving quality of incident reporting.
4. Support transition from National Reporting Learning System (NRLS) and StEIS to new Patient Safety Incident Management System (PSIMS).
5. Implementation of the new Patient Safety Incident Response Framework (PSIRF).
6. Implementation of the framework of involving patients in patient safety.
7. Patient Safety education and training.
8. National Patient Safety Improvement Programmes.
9. COVID-19 recovery planning.

A gap analysis exercise is currently being undertaken against the 9 priorities, leads have been identified to take this work forward aligning to current work streams.

Again the Executive team recognise that this work should be formally acknowledged and given that patient safety underpins the Trusts commitment to continuously improve the quality of our services and care that we provide, it is proposed that the Quality Academy is renamed to the Quality and Patient Safety Academy. Progress will therefore be monitored through the renamed Quality and Patient Safety Academy.

It is also proposed that the current PSSs attend a future Trust Board meeting to provide a more in depth overview of NHS Patient Safety Strategy, the role of the Patient Safety Specialist, Patient Safety Partners and the Trusts approach to achieving the 9 priorities within the strategy.

4	BENCHMARKING IMPLICATIONS
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Not applicable

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5	RISK ASSESSMENT
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Progress will be monitored through the current Quality Academy

6	RECOMMENDATIONS
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1. The Board recognise the Chief Medical Officer as the lead executive for the implementation of the NHS Patient Safety Strategy.
2. The Board agree and approve the change in the Quality Academy to Quality and Patient Safety Academy.
3. The Board to acknowledge the appointment of a full time standalone Patient Safety Specialist role.
4. The Board agree for current Patient Safety Specialists to present to the Board of Directors at a future meeting.

7	Appendices
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NHS Patient Safety Strategy: 2021 Update February 2021