NAMDET 2022

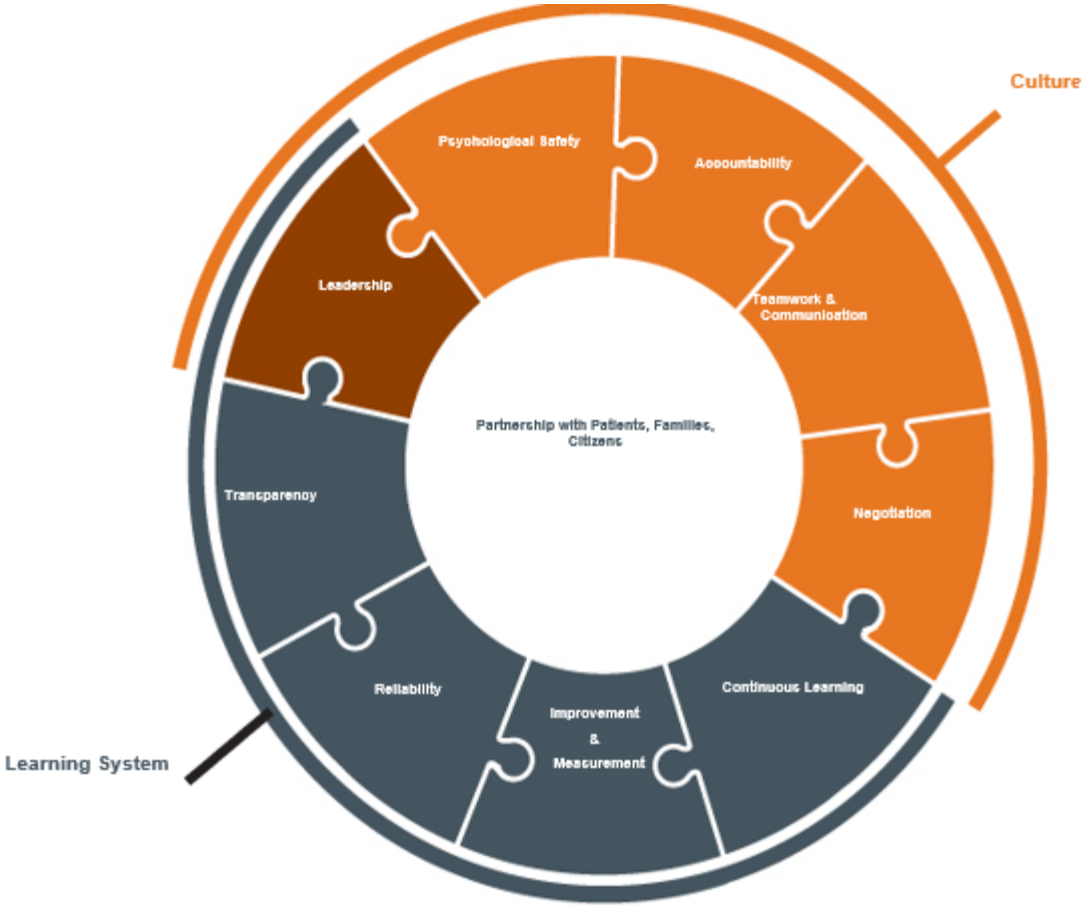
Learning to Connect

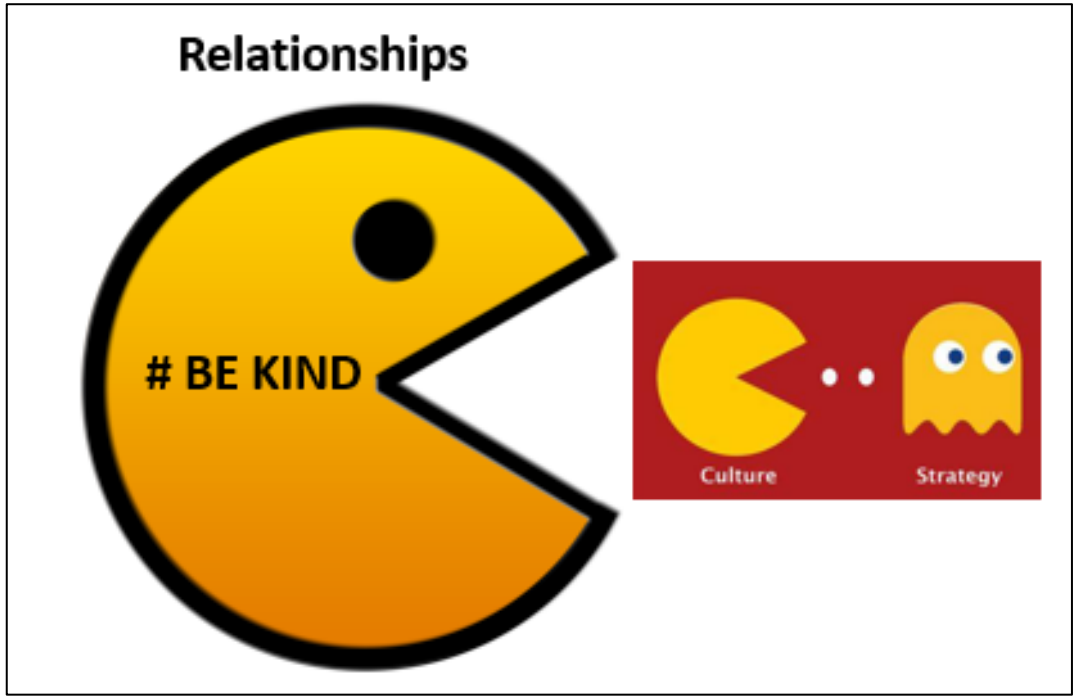
Sarah Jennings, Patient safety clinical lead for medical devices

National Patient Safety team

NHS England

Culture

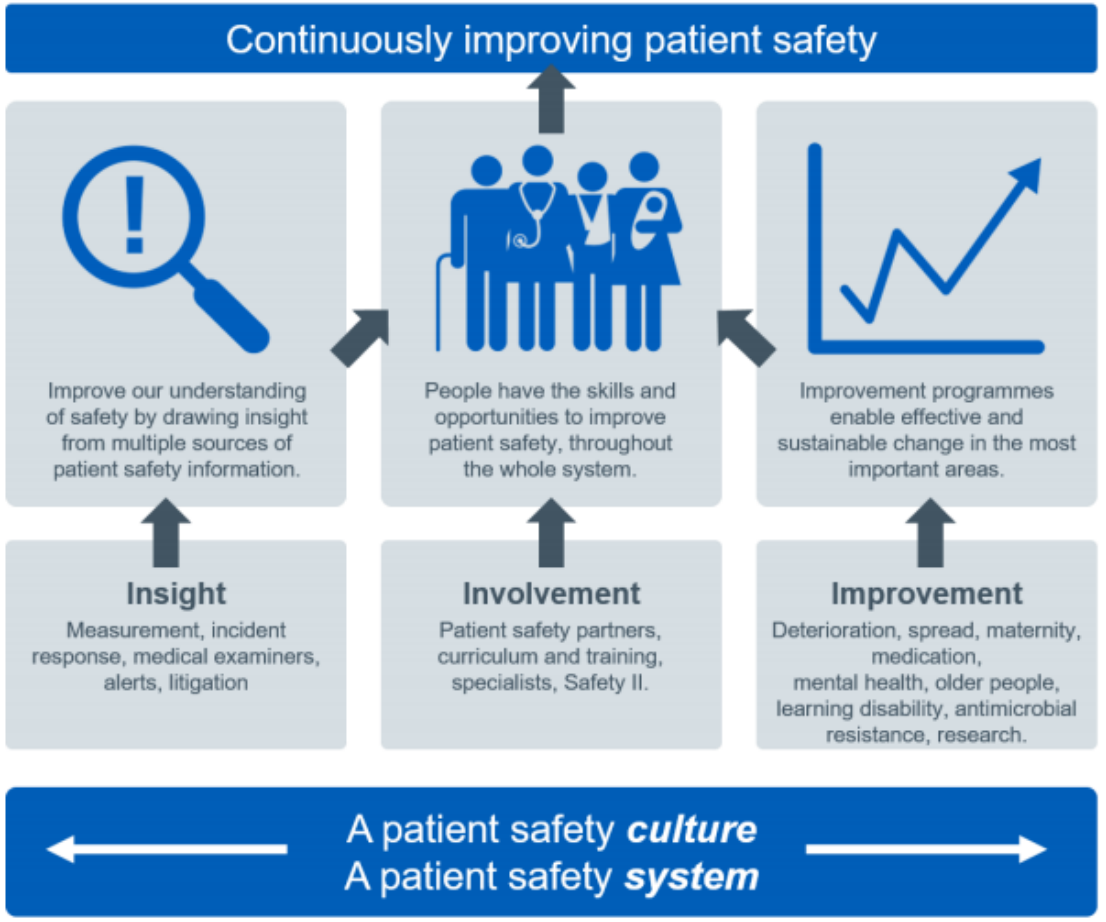

Culture
Psychological Safety
Accountability
Leadership
Teamwork & Communication
Partnership with Patients, Families, Citizens
Transparency
Negotiation
Reliability
Improvement & Measurement
Continuous Learning
Learning System


Relationships
BE KIND
Culture
Strategy

The NHS Patient Safety Strategy

The NHS Patient Safety Strategy provides a structure for all our patient safety work:

- **A patient safety culture** – encouraging engaged, visible leadership promoting openness, just culture and continuous improvement, valuing diversity and equality.
- **Patient safety systems** – governance, accountability, supporting whole systemic and systematic improvement, including primary care, intelligent use of digital.
- **Insight** – a whole organisation commitment to identifying risks, reporting incidents, understanding what contributes to safety, identifying how we normally keep our patients safe
- **Involvement** – a focus on people, giving them the skills and support they need, fundamentally involving patients and the public, recognising the need for specific expertise
- **Improvement** – identification and implementation of improvement priorities using quality improvement science to continuously reduce risks to patients.



The Learn From Patient Safety Events (LFPSE) service

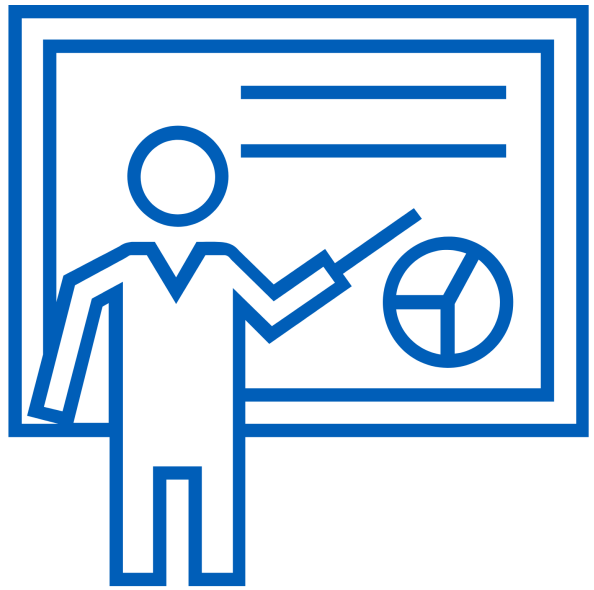
A single port of call for recording, accessing, sharing and learning from patient safety events, in order to support improvement in the safety of NHS-funded services at all levels of the health system

This programme will replace NRLS and STEIS, upgrading aging infrastructure and creating a modern digital service that is fit for purpose and the future.

LFPSE is;

- ✓ More focussed on learning for improvement
- ✓ More suitable for use across the whole of healthcare and not just in hospitals
- ✓ Better aligned with the complexity of modern healthcare delivery
- ✓ Making better use of digital technology

For more information see the LFPSE webpage



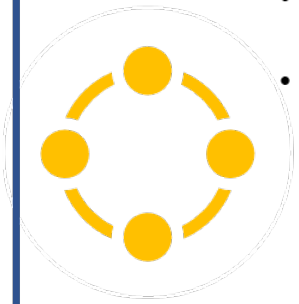
Our vision for Patient Safety Specialists

CQC's thematic review of Never Events recommended that we should ''*create and maintain a network of patient safety leaders to support every NHS organisation, with all working towards a just safety culture that supports the implementation of patient safety alerts and continuous safety improvement*''

- We have therefore established the role of Patient Safety Specialists in providers and local systems to become the backbone of patient safety in the NHS, including in NHS regional teams, regulators and commissioners. There are over 700 Specialists in over 350 organisations
- Patient Safety Specialists will be equipped with the **knowledge and skills** to thrive as safety leaders.
- They will spread understanding across their organisation of the principles, values and behaviours that support a good **patient safety culture**.
- They will support and lead colleagues' safety improvement activities to uphold safety as everyone's business.

The Patient Safety Incident Response Framework

The Patient Safety Incident Response Framework will replace the 2015 Serious Incident Framework and support providers to respond to patient safety incidents and conduct patient safety investigations in a way that maximises opportunities for learning and improvement.



Broader scope:

- It promotes a range of approaches for responding to patient safety incidents
- Moves away from reactive and hard-to-define thresholds for 'Serious Incident' investigation and towards developing a thorough understanding of local patient safety risks and proactively planning the allocation of patient safety incident response resources through the development of Patient Safety Incident Response Plans.

Investigation approach:

- Quality is the priority with the selection of incidents for investigation based on the potential for new learning
- Timeframes are more flexible and set in consultation with the patient and/or family.
- Patient Safety Incident Investigation (PSII) replaces the term root cause analysis (RCA)
- Clarifies that investigations must be led by those trained and experienced in patient safety incident investigation (PSII)

Experience for those affected:

Expectations are clearly set for informing, involving and supporting patients, families, carers and staff involved in patient safety incidents. In accordance with a just culture staff involved in incidents are treated with equity and fairness

Governance and oversight:

- Strengthened, with commissioners and local system leaders assuring plans and co-ordinating investigations spanning multiple settings.
- Provider boards now sign off PSII quality and safety improvements.

Involving patients in patient safety

Key to ensuring safety is that all patients, their families and others are supported to become involved in safety and are able to play a role in keeping patients safe.

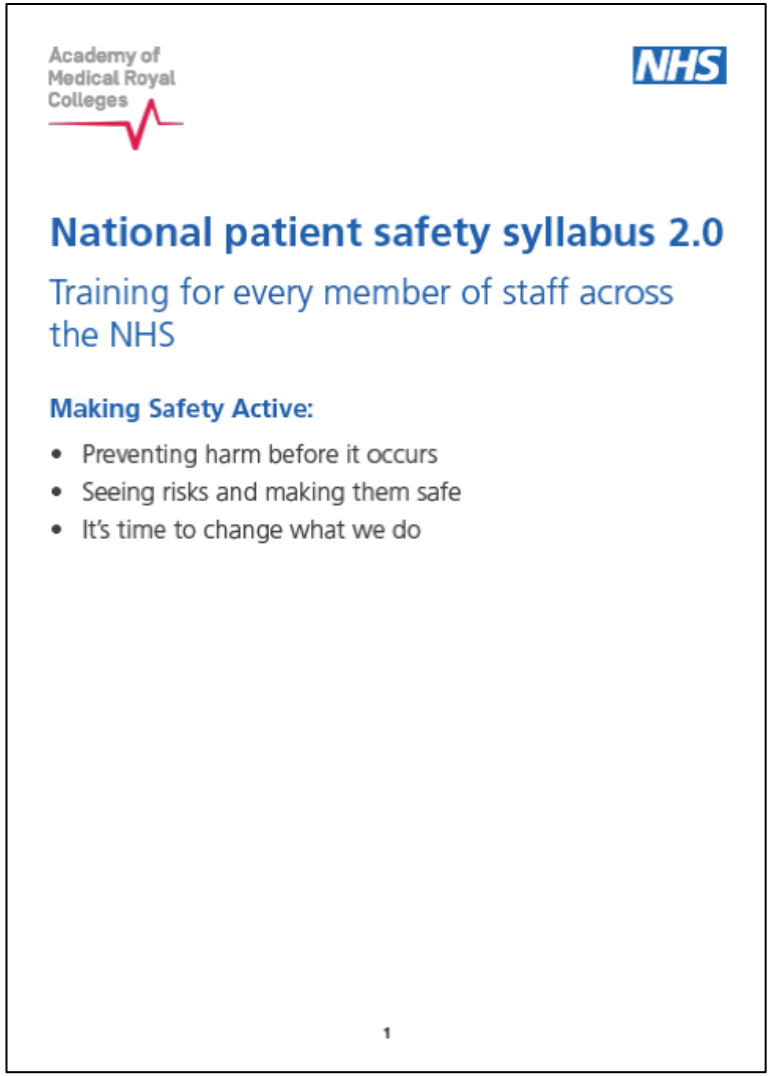
- Our new ‘Framework for involving patients in patient safety’ was published in June 2021.
- This had two key parts
  - Supporting patients, families and carers to contribute to their own safety through simple actions like understanding and asking questions about their treatment as well as highlighting concerns or incidents where they see them
  - Including patients, families, carers and other lay people in safety leadership, particularly on patient safety committees, boards, oversight groups and other clinical governance structures. These are known as ‘patient safety partners’
- Organisations have been asked to appoint at least 2 Patient Safety Partners to their safety-related clinical governance committees (or equivalents) by the end of Q1 2022/23.
- The introduction of PSPs may significantly change the way some organisations approach patient involvement. It requires power sharing, a commitment to openness and transparency between staff and patients, as well as good leadership; it must not be tokenistic.
- For this reason, the framework advocates organisations first assess their ‘readiness’ to engage PSPs.

NHS Patient Safety Syllabus

National Patient Safety Syllabus published by Health Education England in May 2021

- Level 1 (Essentials) comprises:
  - ➢Essentials short introductory animation (all staff)
  - ➢Essentials e-learning educational module (all staff)
  - ➢Essentials e-learning module for Boards and Senior Leadership teams
- Level 2 (Access to Practice) e-learning educational module for those who wish to progress further.
- Levels 3-5 educational modules.
- Certified educational material from other providers will also be included in the delivery of the National Patient Safety Syllabus.

Patient safety specialists will be trained in all 5 levels of the syllabus



Insight

The Insight team implement or supporting a range of initiatives in the Patient Safety Strategy and our statutory functions, centre on:

- Reviewing reported incidents (and other sources) to identify issues needing national action, including through National Patient Safety Alerts (NatPSAs)
- Supporting internal and external partners and researchers to access and review incident data that will help them act on their own areas of patient safety
- Analysing and publishing incident reporting data (NRLS, Never Events, LFPSE) official statistics and associated metrics, and supporting NHSE and external partners to use it in ways that increase transparency and safety, plus FOIs and PQs
- Measurement cycle to support the Patient Safety Strategy and Safety Improvement Programmes, including prioritisation, making the case for research studies, clinical review of incidents to understand the problem, and delving into multiple healthcare databases to identify impact on culture, structure, process and outcomes
- Brokering agreements across ALBs
  - Agreeing common standards and thresholds for NatPSAs (accreditation)
  - Agreeing ‘mutual aid’ for exceptional urgent national patient safety issues
  - Stocktake and cross-ALB action plans for large-scale patient safety issues

The Insight team includes administrative staff,* analysts, and healthcare professionals with human factors and patient safety expertise
*** mentioned first because we rely on their expertise to keep so many plates spinning**

Supporting others to learn from patient safety incident reports/events

Supporting internal and external partners and researchers to access and review incident data that will help them act on their own areas of patient safety, for example:

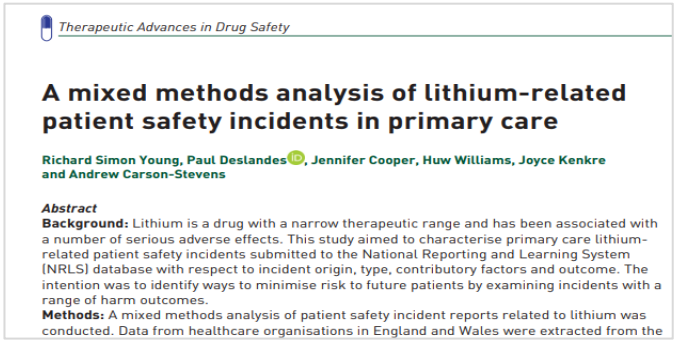
MHRA
Regulating Medicines and Medical Devices

Public Health England

GIRFT
GETTING IT RIGHT FIRST TIME

CareQuality Commission
The independent regulator of health and social care in England

Safe Anaesthesia Liaison Group
RCoA Royal College of Anaesthetists
Association of Anaesthetists
NHS

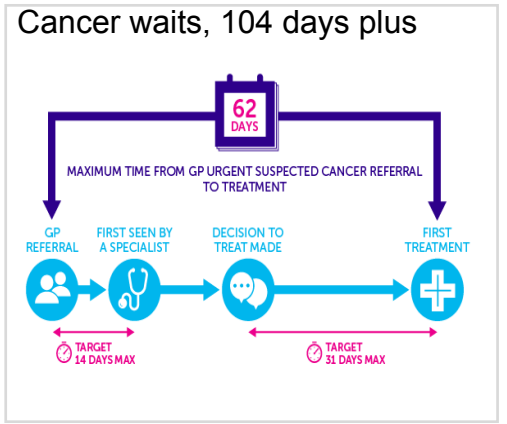


Therapeutic Advances in Drug Safety

A mixed methods analysis of lithium-related patient safety incidents in primary care

Richard Simon Young, Paul Deslandes, Jennifer Cooper, Huw Williams, Joyce Kenkre and Andrew Carson-Stevens

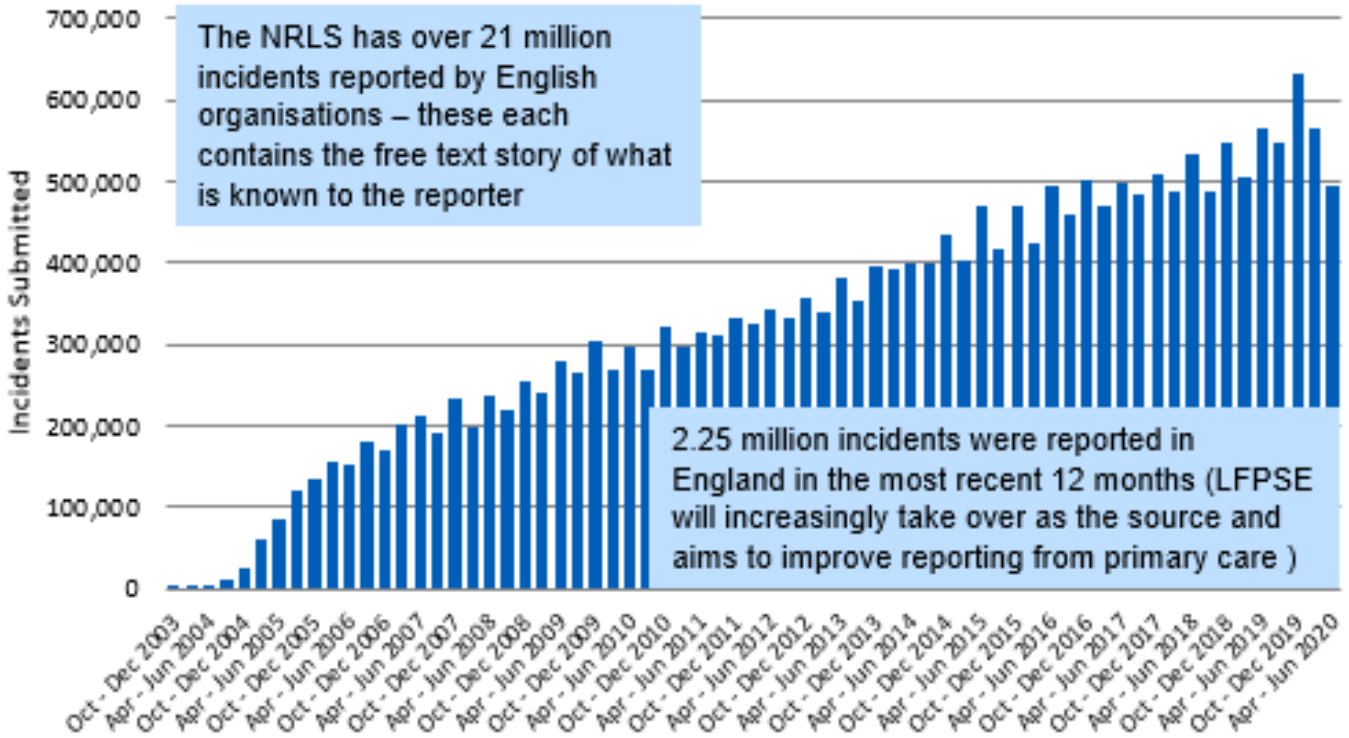
Abstract
Background: Lithium is a drug with a narrow therapeutic range and has been associated with a number of serious adverse effects. This study aimed to characterise primary care lithium-related patient safety incidents submitted to the National Reporting and Learning System (NRLS) database with respect to incident origin, type, contributory factors and outcome. The intention was to identify ways to minimise risk to future patients by examining incidents with a range of harm outcomes.
Methods: A mixed methods analysis of patient safety incident reports related to lithium was conducted. Data from healthcare organisations in England and Wales were extracted from the

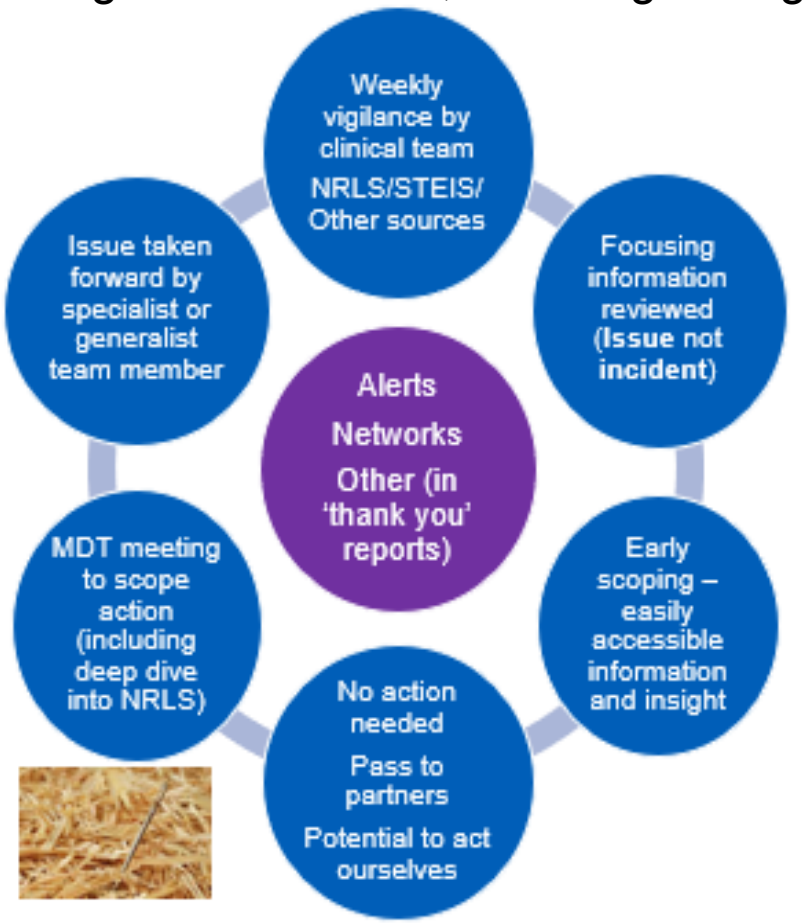


Responding to patient safety events and incident reports

Reviewing reported incidents (and other sources) to identify issues needing national action, including through National Patient Safety Alerts (NatPSAs)

[NHS England » Our National Patient Safety Alerts]





[NHS England » How we acted on patient safety issues you recorded]

Connections

Medical Device Safety Officer: Report Learn Share Act

Report → Learn → Share → Act

NIVAS National Infusion and Vascular Access Society

NICE National Institute for Health and Care Excellence

NAMDET

National Patient Safety Response Advisory Panel

CareQuality Commission · ahpf · The Royal College of Emergency Medicine · National Association for Safety and Health in Care Settings

SAFE ANAESTHESIA LIAISON GROUP · ACADEMY OF MEDICAL ROYAL COLLEGES

MHRA Regulating Medicines and Medical Devices · The Royal College of Anaesthetists · RC PSYCH Royal College of Psychiatrists

The Royal College of Midwives · Royal College of Physicians · RCPCH Royal College of Paediatrics and Child Health

Royal College of Obstetricians & Gynaecologists · Royal College of General Practitioners · Royal College of Nursing · RCR The Royal College of Radiologists

Royal Pharmaceutical Society · The Royal College of Pathologists Pathology: the science behind the cure · RCS Advancing Surgical Standards

NHS England

bsi.

ISO

National Clinical Engineers Network

MHRA

NHS Supply Chain

SAFETY BEGINS WITH TEAMWORK

MSO Network

NHS England

HSIB Healthcare Safety Investigation Branch

Connections to support medical device safety

- Purchasing for safety – connecting with NHS Supply Chain and CAPA. Reviewing purchasing patterns post NatPSA as a view of compliance
- Device design for existing devices, their IFU and product materials, brochures, videos
- Device design for new innovative products and their marketing materials
- Inputting to existing device standards and also new standard proposals to acknowledge usability and system influencers
- Feeding into existing guidance and technical appraisals using report data as post market intelligence

Connections to support medical device safety

- Supporting transition to safer systems / safer devices through connections with professional bodies and industry
- Providing insight to procurement systems and clinical specialities with regard to the impact of device supply disruption and any associated impact to a resultant change in practice
- Early recognition of themes seen during the Covid-19 pandemic which supported connections with those producing rapidly disseminated speciality guides to support staff at the front line and patient safety.
- Connecting to MDSOs by providing patient safety updates at each monthly WebEx
- Connecting with NAMDET through the MDSO network, the MDET magazine and their network

Thank you


'The NHS will last as long as there are folk with the faith to fight for it'
Nye Bevan: founder of the NHS