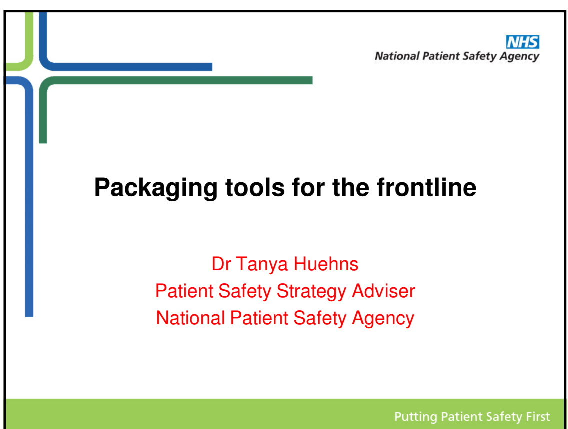
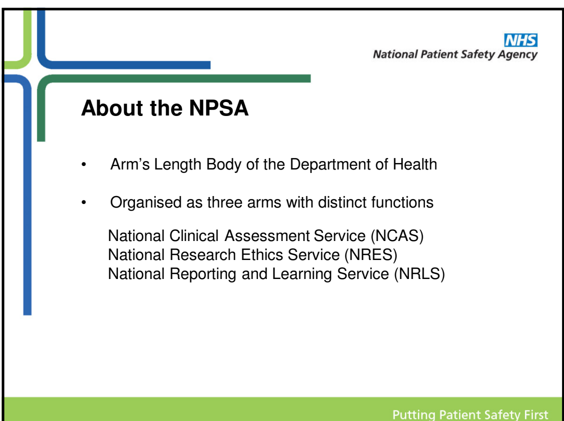
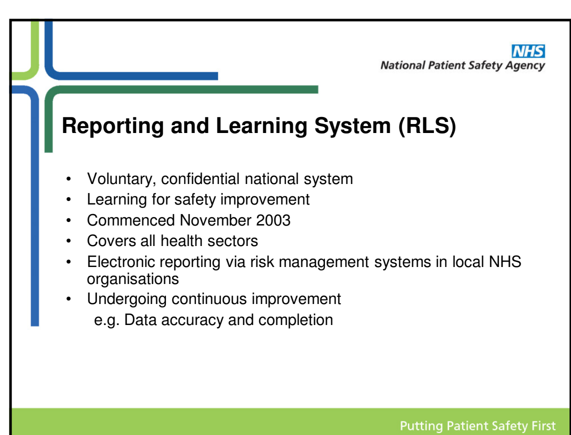

NHS
National Patient Safety Agency
Packaging tools for the frontline
Dr Tanya Huehns
Patient Safety Strategy Adviser
National Patient Safety Agency
Putting Patient Safety First

NHS
National Patient Safety Agency
We've come a long way…
Global context
– patient safety WHO work
National context
– patient safety strong feature of DH work
– NPSA with national reporting system
– NPSA as support agency
Frontline in England
– Providers raising the profile
– Board understanding
– Commissioning for safety, accountability
Putting Patient Safety First


NHS
National Patient Safety Agency
About the NPSA
• Arm's Length Body of the Department of Health
• Organised as three arms with distinct functions
National Clinical Assessment Service (NCAS)
National Research Ethics Service (NRES)
National Reporting and Learning Service (NRLS)
Putting Patient Safety First


NHS
National Patient Safety Agency
Reporting and Learning System (RLS)
• Voluntary, confidential national system
• Learning for safety improvement
• Commenced November 2003
• Covers all health sectors
• Electronic reporting via risk management systems in local NHS organisations
• Undergoing continuous improvement
e.g. Data accuracy and completion
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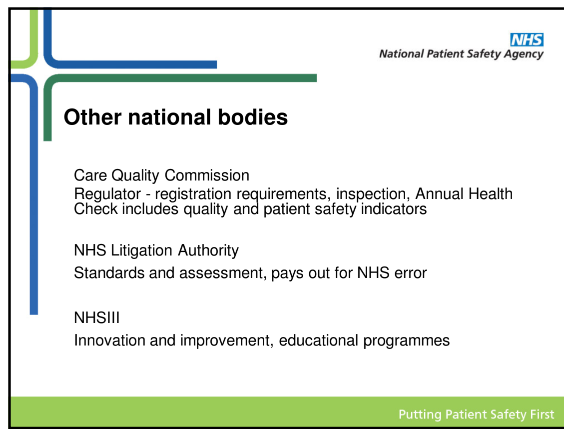
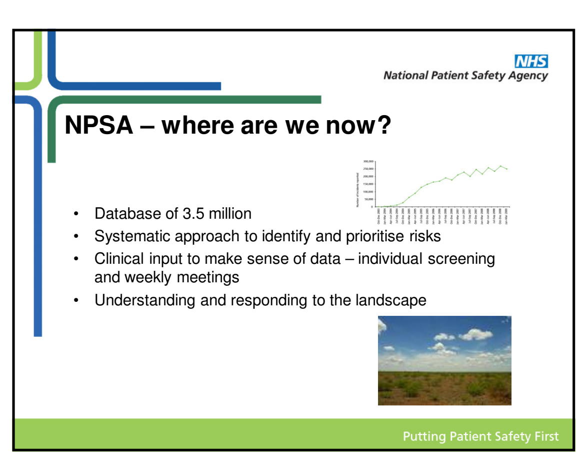

NHS
National Patient Safety Agency
Other national bodies
Care Quality Commission
Regulator - registration requirements, inspection, Annual Health Check includes quality and patient safety indicators
NHS Litigation Authority
Standards and assessment, pays out for NHS error
NHSIII
Innovation and improvement, educational programmes
Putting Patient Safety First


NHS
National Patient Safety Agency
NPSA – where are we now?
• Database of 3.5 million
• Systematic approach to identify and prioritise risks
• Clinical input to make sense of data – individual screening and weekly meetings
• Understanding and responding to the landscape
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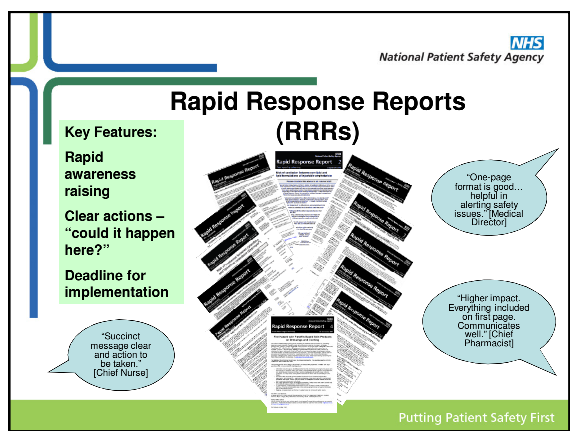
NHS
National Patient Safety Agency
Rapid Response Reports (RRRs)
Key Features:
Rapid awareness raising
Clear actions – "could it happen here?"
Deadline for implementation
"One-page format is good… helpful in alerting safety issues." [Medical Director]
"Higher impact. Everything included on first page. Communicates well." [Chief Pharmacist]
"Succinct message clear and action to be taken." [Chief Nurse]
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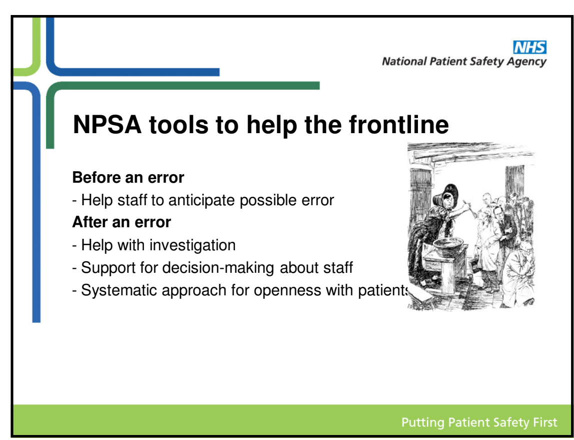
NHS
National Patient Safety Agency
NPSA tools to help the frontline
Before an error
- Help staff to anticipate possible error
After an error
- Help with investigation
- Support for decision-making about staff
- Systematic approach for openness with patients
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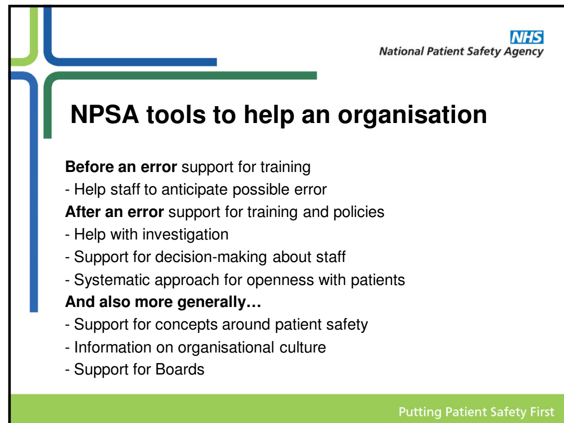
NHS
National Patient Safety Agency
NPSA tools to help an organisation
Before an error support for training
- Help staff to anticipate possible error
After an error support for training and policies
- Help with investigation
- Support for decision-making about staff
- Systematic approach for openness with patients
And also more generally…
- Support for concepts around patient safety
- Information on organisational culture
- Support for Boards
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NHS
National Patient Safety Agency
Finding root causes needs quality investigation
Visual discrimination (Vinca-alkaloids)
Standardisation
Changing attitudes
use the NHS Number
Clean Hands Save Lives
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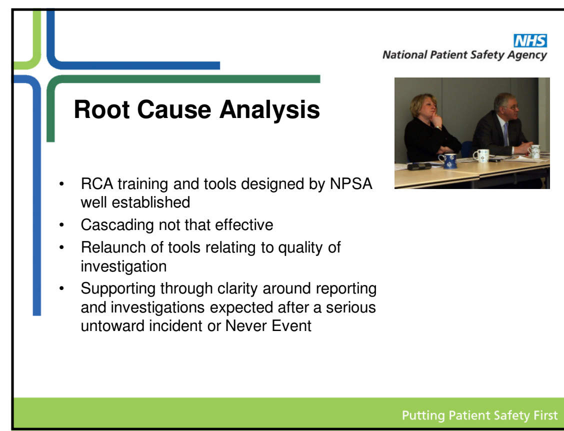
NHS
National Patient Safety Agency
Root Cause Analysis
RCA training and tools designed by NPSA well established
Cascading not that effective
Relaunch of tools relating to quality of investigation
Supporting through clarity around reporting and investigations expected after a serious untoward incident or Never Event
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NHS
National Patient Safety Agency
Recent developments
Resources to improve credibility/thoroughness of reports
Investigation report template
Guide to report writing
Guidance around three levels of investigation
Investigation report evaluation tool
Re-launch of RCA training by NPSA
2 day course for lead investigators
rcatraining@npsa.nhs.uk
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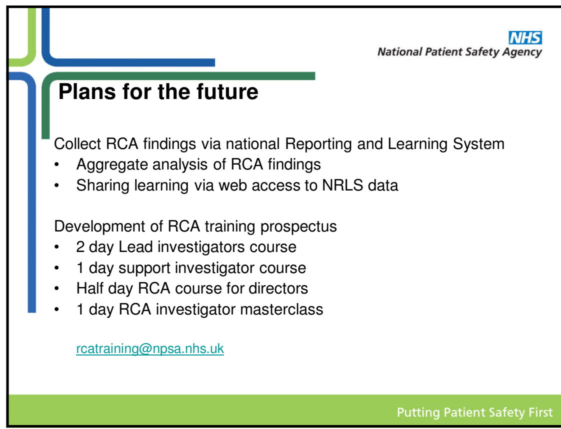
NHS
National Patient Safety Agency
Plans for the future
Collect RCA findings via national Reporting and Learning System
• Aggregate analysis of RCA findings
• Sharing learning via web access to NRLS data
Development of RCA training prospectus
• 2 day Lead investigators course
• 1 day support investigator course
• Half day RCA course for directors
• 1 day RCA investigator masterclass
rcatraining@npsa.nhs.uk
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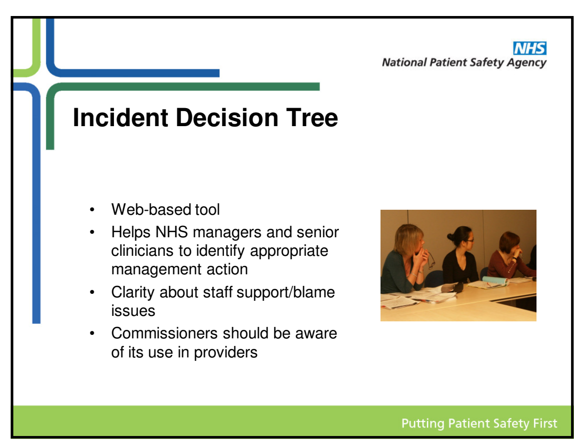
NHS
National Patient Safety Agency
Incident Decision Tree
• Web-based tool
• Helps NHS managers and senior clinicians to identify appropriate management action
• Clarity about staff support/blame issues
• Commissioners should be aware of its use in providers
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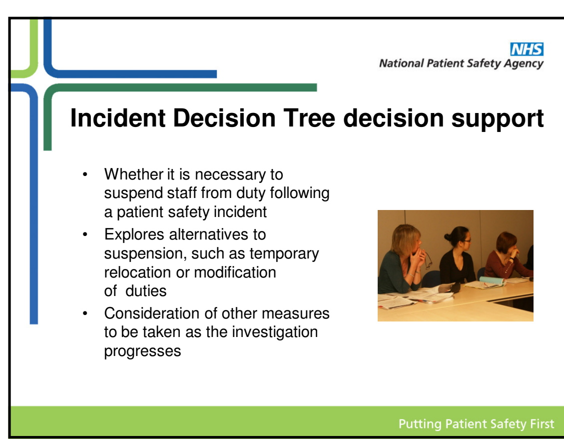
NHS
National Patient Safety Agency
Incident Decision Tree decision support
• Whether it is necessary to suspend staff from duty following a patient safety incident
• Explores alternatives to suspension, such as temporary relocation or modification of duties
• Consideration of other measures to be taken as the investigation progresses
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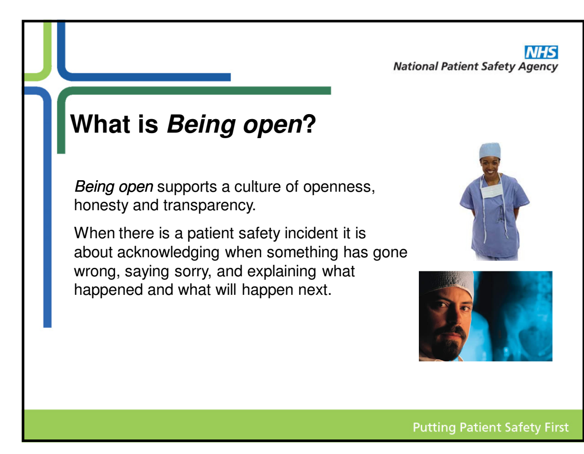
NHS
National Patient Safety Agency
What is Being open?
Being open supports a culture of openness, honesty and transparency.
When there is a patient safety incident it is about acknowledging when something has gone wrong, saying sorry, and explaining what happened and what will happen next.
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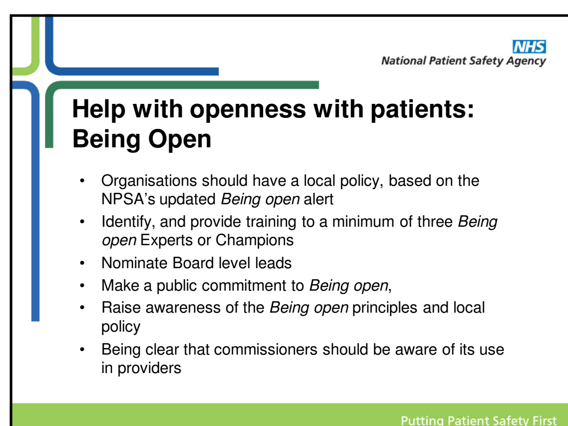
NHS
National Patient Safety Agency
Help with openness with patients: Being Open
• Organisations should have a local policy, based on the NPSA's updated Being open alert
• Identify, and provide training to a minimum of three Being open Experts or Champions
• Nominate Board level leads
• Make a public commitment to Being open,
• Raise awareness of the Being open principles and local policy
• Being clear that commissioners should be aware of its use in providers
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NHS
National Patient Safety Agency
Concepts of patient safety: Seven Steps
STEPS
Seven steps to patient safety
Step 1 Build a safety culture
Step 2 Lead and support your staff
Step 3 Integrate your risk management activity
Step 4 Promote reporting
Step 5 Involve and communicate with patients and the public
Step 6 Learn and share safety lessons
Step 7 Implement solutions to prevent harm
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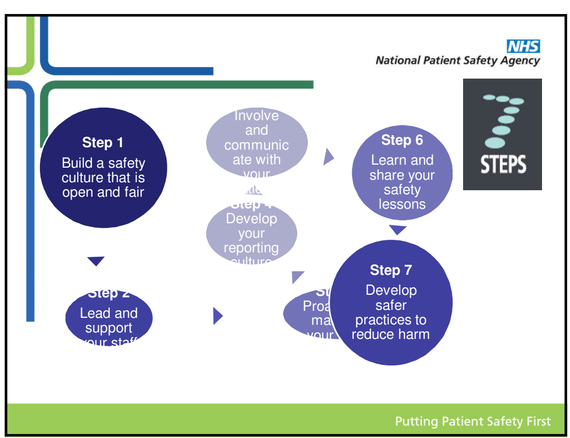
NHS
National Patient Safety Agency
Step 1
Build a safety culture that is open and fair
Step 6
Learn and share your safety lessons
Step 7
Develop safer practices to reduce harm
Lead and support
STEPS
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NHS
National Patient Safety Agency
Strengthening the concepts around Seven Steps
Specialty and setting specific advice
• Mental Health version
• General practice
STEPS
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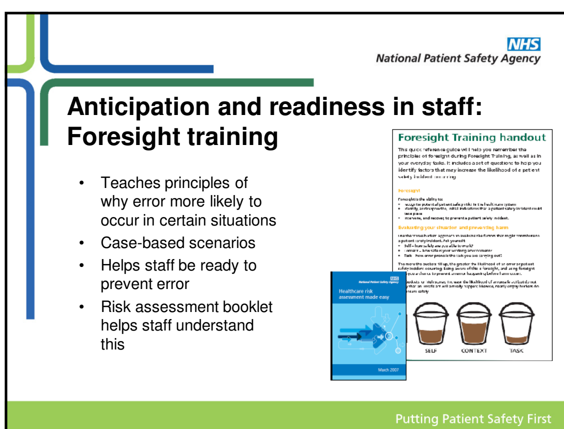
NHS
National Patient Safety Agency
Anticipation and readiness in staff: Foresight training
• Teaches principles of why error more likely to occur in certain situations
• Case-based scenarios
• Helps staff be ready to prevent error
• Risk assessment booklet helps staff understand this
Foresight Training handout
SELF
CONTEXT
TASK
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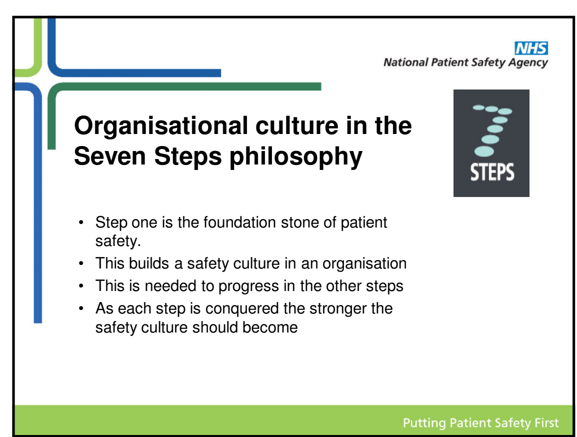
NHS
National Patient Safety Agency
Organisational culture in the Seven Steps philosophy
STEPS
• Step one is the foundation stone of patient safety.
• This builds a safety culture in an organisation
• This is needed to progress in the other steps
• As each step is conquered the stronger the safety culture should become
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NHS
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Help with understanding an organisation: Culture tool (MaPSaf)
Manchester Patient Safety culture tool
• Reflective tool to assess safety culture
• Team and organisational level
• Most widely used culture assessment tool in the NHS
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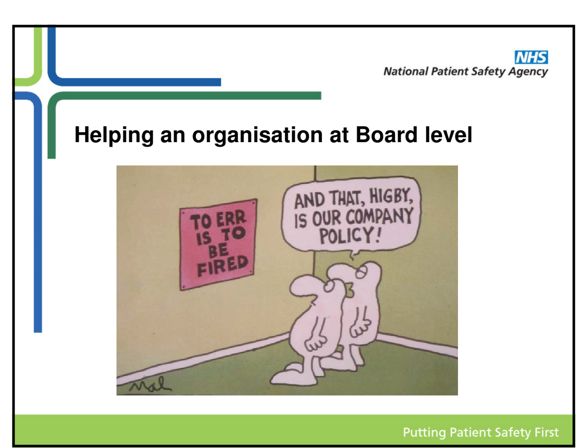
NHS
National Patient Safety Agency
Helping an organisation at Board level
TO ERR IS TO BE FIRED
AND THAT, HIGBY, IS OUR COMPANY POLICY!
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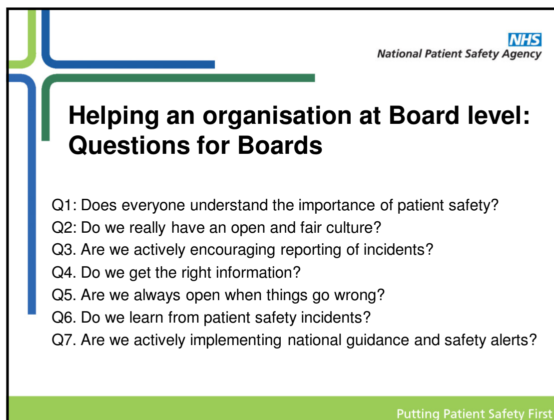
NHS
National Patient Safety Agency
Helping an organisation at Board level: Questions for Boards
Q1: Does everyone understand the importance of patient safety?
Q2: Do we really have an open and fair culture?
Q3. Are we actively encouraging reporting of incidents?
Q4. Do we get the right information?
Q5. Are we always open when things go wrong?
Q6. Do we learn from patient safety incidents?
Q7. Are we actively implementing national guidance and safety alerts?
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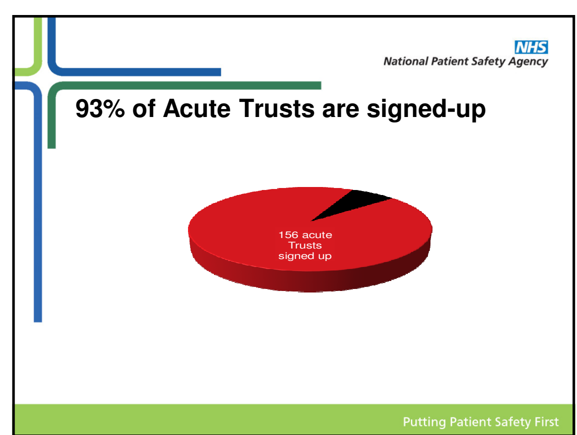
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National Patient Safety Agency
93% of Acute Trusts are signed-up
156 acute Trusts signed up
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NHS
National Patient Safety Agency
Next steps
Build on what we already have created
Better implementation
Continue to tailor messages
Penalties/incentives?
Response of public
Board understanding – enough?
Will there and skills in place?
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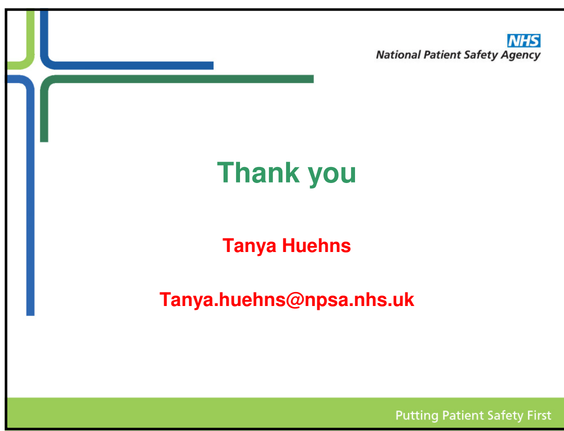
NHS
National Patient Safety Agency
Thank you
Tanya Huehns
Tanya.huehns@npsa.nhs.uk
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