



NHS Patient Safety Strategy: 2021 update

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Foreword

When we published the NHS patient safety strategy in 2019, we committed to updating it periodically to maintain our focus in an evolving healthcare landscape on those activities that will have greatest impact on safety improvement. While the principles and high-level objectives of the strategy remain unchanged, we have recognised the need for some shift in scope.

We have updated our tables of deliverables to include the extra work we will be doing. An explicit new objective I would like to highlight is the development of an evidence base to identify how we can most effectively contribute to reducing health inequalities. There is increasing evidence of disparities in healthcare outcomes and interactions between different ethnic groups, e.g. in [COVID-19](#) outcome, maternal mortality and mental health provision. Socioeconomic status and where in the country someone lives also impact on morbidity and mortality. Evidence about disparities in the safety of healthcare experienced by different groups is often lacking or inconclusive; this limits our ability to design system-level initiatives that may help to address these health inequalities. We must also look at our existing programmes and ways of working to ensure that we take every opportunity to address issues of equality, diversity and inclusion.

After a year establishing the strategy initiatives and adapting them for what is becoming the 'new normal', we expect to meet some significant progress milestones in 2021: expansion of the patient safety specialist network, publication of the patient safety partners framework and roll out of the new patient safety incident management system. As ever we are grateful for the continued support and energy of colleagues and patients in bringing such strategies to life, working towards a shared vision for patient safety in the NHS.



Aidan Fowler
NHS National Director of Patient Safety

A view from patient safety partners

We want to take the opportunity to highlight the importance of patients, carers and families not just as beneficiaries of the strategy but also key participants in delivering it. As patient safety partners (PSPs) and members of the strategy oversight committee, we bring our experiences and perspectives to steer implementation of this strategy across the board and ensure that the focus on patients is not lost among the progress reports, NHS jargon and wider strategic issues raised. We provide the opportunity to ensure that the patient voice from all communities – especially those with health inequalities – is being embedded into the Patient Safety Strategy through appropriate communication and engagement channels; the importance of which has been demonstrated over the last year by COVID-19 disproportionately affecting those from black, Asian and minority ethnic (BAME) communities.

Understandably, one of the strategy objectives closest to our hearts is the patient safety partner framework which aims to emulate this model of involvement of patients, carers and families in patient safety throughout the NHS. Our aspirations for this work include having a diverse representation of PSPs within organisations that reflects the local population, with the training and support available to enable this.

A clear enabler for this is to align work on the patient safety syllabus and the PSP framework.

The next few months provide a crucial window of opportunity to facilitate this, as we oversee in parallel how consultation feedback is reflected in the PSP framework, and how production of the patient safety syllabus (and broader education and training goals) reflect the patient and public voice.

There are many patient representatives besides us who are actively contributing to delivery of the patient safety strategy, and on behalf of the strategy oversight committee we thank them all for the valuable insight they continue to contribute in what is an especially challenging and hard time for us all.

Angela Hamilton, Khudeja Amer-Sharif and Neill Vinter

Patient Safety Partners

What has changed and why?

Equality, diversity and inclusion

The most significant strategy update is the new commitment to address patient safety inequalities, with a new objective added to the safety system strand of the strategy. We have also reviewed how we are implementing all other objectives to identify what more we can do to reduce inequalities.

We are committed to identifying whether and how current patient safety culture and mechanisms contribute to health inequalities, including by engaging with patient, staff and other stakeholder groups. We will then set specific actions for the national patient safety team, local stakeholders and individual clinicians to address inequalities in patient safety.

Our ambition to meet the needs of specific vulnerable groups continues in the improvement strand – notably the objectives to address the safety issues faced by older people and people with a learning disability. We recognise that a comprehensive plan to address patient safety inequalities must consider how multiple inequalities combine to affect outcomes for particular patient groups. For example, [last year's LeDeR annual report](#) said that in 2019 people with a learning disability from BAME groups “died disproportionately at younger ages than white British people. Of those who died in childhood (ages 4 to 17 years), 43% were from BAME groups.”

Impact of COVID-19 on strategy implementation

We have revised several of the original strategy timelines to reflect the disruption and uncertainty arising from the pandemic. Some uncertainty continues and the new timelines are based on assumptions about colleague and service capacity to implement new initiatives in 2021 and beyond.

Disrupted plans aside, colleagues delivering the strategy workstreams have shown enormous adaptability.

- Our national patient safety insight team prioritised the identification of COVID-19 related risks to support the system's rapid learning as it responded to the pandemic.

- The national patient safety improvement programmes focused on supporting the NHS COVID-19 response, e.g. how to manage deterioration.
- Medical examiners provided their acute trusts with invaluable on the ground support.
- The national team issued a regular COVID-19 patient safety update for patient safety leaders.

The COVID-19 response has underlined the value that medical examiners and patient safety specialists could have in any future pandemic response or other national health crisis. We have sought to accelerate the rollout of these programmes. The Royal College of Pathologists adapted the medical examiner training for online delivery, and the patient safety specialist initiative was launched.

We continue to issue regular (monthly) communications to patient safety colleagues, to keep our growing community of patient safety specialists sighted on national patient safety news.

Patient safety infrastructure

This refresh translates the high-level objectives for the safety culture and safety system strands of the strategy into more tangible deliverables. We will create a dedicated space to share insight on safety culture indicators and offer guidance on how to identify and address culture issues. We do not intend safety culture indicators to be used to assess organisation performance or for regulatory purposes. The goal of this programme is solely to support and enable organisations to improve their safety culture through embedding a continuous cycle of understanding the issue – developing a plan – delivering the plan – evaluating the outcome.

We have also updated the principles underpinning all the national safety improvement programmes to reflect our exploration of a cross-cutting ‘key enablers’ workstream.

What may not be apparent from the updated objectives and deliverables is the ongoing work to develop the networks of organisations and individuals who are working directly with us to achieve the strategy’s goals. We held our first online meeting with registered patient safety specialists in October 2020; their energy and enthusiasm will galvanise the formation of effective local networks over the next few months. Trusts had until the end of November to let us know who they had identified as their patient safety specialists and we look forward to involving them in our work to develop the role, notably that on the patient safety syllabus and patient safety education and training. We

have started the pilot phase of adoption of the Patient Safety Incident Response Framework and several early adopter organisations have managed to maintain their preparatory work throughout the pandemic.

Technical updates

The tables below include all the updates to the original strategy and the new objectives. New items under 'What and by when' largely replace non-specific items, or they clarify milestones that in 2019 were insufficiently developed. Those that have been achieved have been removed ([as recorded in the strategy progress report published in September 2020](#)) as have others for which the learning from the last year has shown very limited potential for further alignment and value from their explicit inclusion in the strategy.

Table 1: Safety culture objectives

Objective	Who will deliver this	What and by when	Changes from the original deliverables (shown in grey)
<p>Monitor the development of a safety culture in the NHS</p>	<p>National patient safety team</p>	<p>Assess whether additional safety culture questions in the staff survey would have value by Q4 2020/21.</p> <p>Complete a discovery phase for a safety culture data ‘visualisation tool’ by Q2 2021/22, which includes identifying potential new metrics related to safety cultures in the scope.</p>	<p>Updated to reflect the 2020 changes to the NHS staff survey and plans for its future development.</p> <p>Original:</p> <p>NHS staff survey q17 (fairness and effectiveness of reporting) and q18 (staff confidence and security in reporting), published annually every spring.</p> <p>Explore the introduction of further metrics related to safety cultures, e.g. monitoring levels of staff suspension and of anonymous incident reporting.</p>
		<p>Explore the safety culture characteristics of highly safe NHS trusts, and share insights by Q1 2021/22.</p> <p>The maternity and neonatal safety improvement programme will ascertain how insights from the initial safety culture survey are being used and what key interventions high scoring organisations are using during 2021/22, ahead of repeat culture surveys.</p>	<p>Updated to make the deliverables more specific.</p> <p>Original:</p> <p>Monitoring progress in relation to the well-led framework via CQC inspection outcomes as published</p>
<p>Support the development of a safety culture in the NHS</p>	<p>National patient safety team</p>	<p>Establish the safety culture work programme to bring together data, research and practical support for safety culture improvement by Q1 2021/22.</p>	<p>New deliverables added to specify national action to support safety culture development.</p>

		<p>Produce a safety culture guide to help organisations implement specific improvement activities by Q1 2021/22 (see key enablers objective under Safety system).</p> <p>Extend the exploration of safety culture processes and infrastructure to mental health, community and primary care settings by Q4 2021/22.</p> <p>Continue to establish and test safety culture interventions to support local systems, as part of the key enablers objective.</p>	
	Local systems	<p>Local systems to set out how they will embed the principles of a safety culture on an ongoing basis.</p> <p>These should include monitoring and response to NHS staff survey results and any other safety culture assessments, adoption of the NHS England and NHS Improvement 'A Just Culture Guide' or equivalent, adherence to the well-led framework and 100% compliance declared for National Patient Safety Alerts by their action complete deadlines.</p>	<p>Updated to include compliance with National Patient Safety Alerts which was previously in a different section of the strategy.</p>

Table 2: Safety system objectives

Objective	Who will deliver this	What and by when	Changes from the original deliverables
<p>Clarify who does what in relation to patient safety</p>	<p>National patient safety team</p>	<p>Develop the National Patient Safety Committee (see specific deliverable under Insights).</p> <p>Explore the existing provision of information to patients about raising patient safety issues and concerns, and assess if there is a gap, by Q1 2021/22.</p>	<p>Updated to reflect the fact that patient safety is an evolving landscape requiring the continual development of working relationships between organisations to respond to new challenges.</p> <p>Updated to reflect patient feedback on information needs.</p> <p>Original: Publish a definitive guide to who does what in relation to patient safety</p>
<p>Support workforce development through the NHS People Plan</p>	<p>National patient safety team and the NHS England and NHS Improvement Workforce Policy and Strategy team</p>	<p>Identify by Q1 21/22 how we can contribute to We are the NHS: People Plan for 2020/2021, specifically in relation to plans for:</p> <ul style="list-style-type: none"> • bringing more people into the NHS to implement the Long Term Plan • addressing health inequalities, embedding health and wellbeing support and fostering a culture of trust • fostering a culture of belonging in trusts, STPs, ICSs and across directorates • facilitating new ways of working and delivering care • education and training for executives and leaders • increased places for undergraduates in nursing, allied health professions and medicine, including patient safety modules in the programmes. <p>Co-develop a plan for collaboration by Q2 2021/22.</p>	<p>Updated to align with the People Plan published in July 2020.</p>

<p>Support quality planning, surveillance, and improvement through NHS England and NHS Improvement quality governance processes</p>	<p>National patient safety team and the NHS England and NHS Improvement Quality Strategy team</p>	<p>Identify by Q1 2021/22 how we can ensure safety strategy alignment within quality strategy in local systems, with regard to:</p> <ul style="list-style-type: none"> • promoting a shared view of quality • embedding quality (including safety) into ICS structures. <p>Aligning with governance and reporting mechanisms. Co-develop a plan for collaboration by Q2 2021/22.</p>	<p>New objective added to ensure the strategy translates to local system leadership structures and processes as they continue to develop.</p>
<p>Ensure understanding of patient safety is embedded across regulatory bodies</p>	<p>National patient safety team working with regulators</p>	<p>Enable within regulatory bodies:</p> <ul style="list-style-type: none"> • uptake of the training in the essentials of patient safety by Q1 2023/24 • identification of their regulatory body patient safety specialist by Q1 2021/22. • inclusion of two patient safety partners on their safety-related clinical governance committees (or equivalents) by Q1 2022/23. 	<p>Updated to include dates. Original: Encourage:</p> <ul style="list-style-type: none"> • uptake of the new patient safety curriculum and training • contribution to the patient safety specialist network • commitment to patient safety partners.
<p>Reflect patient safety in the digitisation agenda</p>	<p>NHSX, working with the national patient safety team, clinical leaders and NHS Digital</p>	<p>Co-develop and implement a work programme with the leads of NHSX Mission 4 (patient safety) by Q2 2021/22.</p>	<p>Updated to recognise the establishment of NHSX Mission 4 (Patient Safety). Original: Make the safety case for the initiatives in Chapter 5 of the NHS Long Term Plan including:</p> <ul style="list-style-type: none"> • EPMA implementation • record digitisation and data linkage • patient access to their records • clinical decision support.

Enhance safety in primary care	National patient safety team working with primary care leaders	Scope and produce a primary care patient safety plan by Q2 2021/22, to include: <ul style="list-style-type: none"> • how primary care involvement can be expanded in the national patient safety improvement programmes (NatPatSIPs) • how the developing NHSX programme relates to primary care. 	Removed the following as the programme draws to a close: Support the Keeping General Practice Safe component of the 2019 to 2021 GP IT operating model.
		Expanding incident reporting in primary care by replacing the National Reporting and Learning System (NRLS) from Q1 2021/22.	Updated to include the planned roll-out schedule.
Patient safety equality, diversity and inclusion	National patient safety team	<p>Review and update the equality impact assessments for patient safety strategy initiatives by Q2 2021/22.</p> <p>Identify how to improve our equality data collection capability across the strategy (e.g. Patient Safety Incident Management System [PSIMS], medical examiners, specialists, patient safety partners) by Q1 2021/22.</p> <p>Review the evidence base on patient safety health inequalities in the NHS by Q4 2020/21.</p> <p>Develop a roadmap for addressing patient safety inequalities at a strategic level by Q3 2021/22.</p> <p>Include guidance for diverse representation in initiatives such as Patient Safety Partner recruitment by Q3 2021/22.</p> <p>Continue to establish and test interventions to address inequalities and co-design as part of the key enablers improvement work.</p>	New objective added to recognise that we do more to explicitly address health inequalities in patient safety.

<p>Deliver key enablers of patient safety improvement</p>	<p>Local systems supported by the national patient safety team and the patient safety collaboratives (PSCs)</p>	<p>Addressing Inequalities – support patient safety networks to undertake a mapping exercise by Q1 2021/22 to better understand their populations with respect to demography, ethnicity and social deprivation factors, and use the insights to prioritise local improvement approaches to ensure they are addressing inequalities.</p> <p>Patient and carer co-design – support patient safety networks to identify their current levels of patient and public voice (PPV) co-design around patient safety improvement by Q2 2021/22, to ensure it reflects the diversity of the population served.</p> <p>Safety culture – develop and publish a patient safety culture guide (see safety culture).</p> <p>Patient safety improvement networks – PSCs to set up and support the development of networks to provide the delivery architecture for each safety improvement programme: maternity and neonatal by Q1 2021/22 and deterioration, care homes and mental health by Q4 2021/22 or sooner.</p> <p>Improvement leadership – PSCs to identify aspiring local improvement leaders (including clinical leaders) by Q2 2021/22 and support their development, demonstrating diversity and equality of opportunity in all safety improvement work.</p> <p>Building safety improvement capacity and capability – patient safety networks to identify specific improvement capability needs of each national programme by Q2 2021/22 and build targeted safety improvement capacity and capability, using a dosing approach, where specific needs are identified.</p> <p>Local measurement for improvement – PSCs to support systems and organisations to adopt a measurement for improvement approach and local measurement plans by Q1 2021/22, to measure testing and the impact of interventions in line with the national strategy patient safety measurement principles.</p>	<p>New objective replaces the following, which is business as usual: Enhance the impact of the national patient safety improvement programmes.</p>
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		<p>Improvement and innovation pipeline – develop and test an improvement and innovation pipeline by Q2 2021/22 and use this to inform and prioritise future improvement work.</p> <p>To build on links with local systems and regional teams in all safety improvement activity.</p>	
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Table 3: Insight objectives

Objective	Who will deliver this	What and by when	Changes from the original deliverables
Embed the principles of patient safety measurement nationally and work with other organisations to spread adoption	National patient safety team	<p>Formulate a measurement strategy for the NatPatSIPS by Q4 2020/21.</p> <p>Publish data request prioritisation framework for provision of data to external requestors by Q3 2020/21.</p> <p>Continue work with external organisations to encourage adoption of the national strategy patient safety measurement principles.</p> <p>Ongoing publication of regular incident reporting statistics, including official statistics.</p>	<p>Updated to be more specific.</p> <p>Original:</p> <p>Embed the principles of patient safety measurement nationally and work with other organisations to spread adoption.</p>

Deliver replacement for the National Reporting and Learning System (NRLS) and Strategic Executive Information System (StEIS)	National patient safety team	<p>Start transition from NRLS to the Patient Safety Incident Management System in Q4 2020/21 (subject to agile system development processes and Government Digital Service approvals).</p> <p>Develop business support applications to enable analysis of reported information.</p> <p>Identify the best way to request equalities information in the data collection.</p>	<p>Removed the following as the goal has been achieved: Incorporate learning from what goes well (Safety II) in the development of the NRLS replacement.</p> <p>Updated to reflect clarified milestones.</p>
		Ongoing feedback to local systems to improve reporting.	No change.
	Local systems	Local systems, including current non-reporters, to connect to the new system by end Q4 2021/22 subject to local software compatibility.	<p>Updated timeline.</p> <p>Removed as repetition of the national goal to improve reporting: Continuous increase in effective incident reporting.</p>
Implement the new Patient Safety Incident Response Framework (PSIRF)	National patient safety team, NHS England and NHS Improvement national and regional teams, and early adopter organisations	<p>By Q4 2020/21 begin work with HSIB to support the testing and introduction of national patient safety incident investigation training.</p> <p>Develop investigation training supplier procurement framework by Q4 2020/21 as an interim measure before national training is made available.</p>	<p>Removed the following as the goal has been achieved: Establish PSIRF national implementation group in Q2 2019/20.</p> <p>Updated to reflect work to support HSIB ambition to develop patient safety incident investigation training.</p> <p>Original: Develop investigation training supplier procurement framework by Q4 2020/21.</p>
		Develop supporting resources for early adopters to support implementation up to Q4 2021/22.	<p>Updated to be more specific about tasks and timeline.</p> <p>Original: Develop resources for boards to support implementation, including incorporating relevant content into existing board development programmes by Q4 2019/20.</p>

		<p>Conclude work with regional colleagues and early adopters across several local systems to gain insight into how best to implement the PSIRF by Q4 2021/22.</p> <p>Update the equality impact assessment for the national PSIRF programme and support early adopters to address health inequalities in their piloting of the framework in Q4 2020/21.</p> <p>Publish resources to support rollout after the early adopter pilot concludes in Q4 2021/22.</p> <p>Start national rollout by Q1 2022/23.</p>	<p>Updated to reflect progress, addition of specific equality work and updated timelines.</p> <p>Original:</p> <p>Regional team oversight roles and responsibilities developed to support ambitions of the PSIRF.</p> <p>Work with early adopters across several local systems to gain insight into how best to implement the PSIRF.</p>
		<p>Local systems to plan how they will prepare for and support implementation of the PSIRF. This should be informed by nationally shared early adopter experience. Initially local systems should:</p> <ul style="list-style-type: none"> • identify PSIRF implementation lead(s) by beginning Q3 2021/22 • review current resource (in terms of skills, experience, knowledge and personnel) and subsequent action required from beginning Q4 2021/22, to ensure organisations across the local system are equipped to respond to patient safety incidents as described in the PSIRF, and to undertake patient safety incident investigation (PSII) as describe in the PSII standards: <ul style="list-style-type: none"> – NB: leaders and staff must be appropriately trained in responding to patient safety incidents, including PSII, according to their roles,¹ with delivery of that training from Q4 2021/22 onwards 	<p>Updated timeline.</p> <p>Original:</p> <p>Local systems set out in their LTP implementation plans how they will implement the new PSIRF. Full implementation is anticipated by July 2021, informed by early adopter experience. Initially plans should:</p> <ul style="list-style-type: none"> • identify PSIRF leads in local systems by Q4 2019/20 • anticipate development of organisational-level strategic plans for patient safety investigation and review by the end of Q2 2020/21 • ensure that leaders and staff are appropriately trained in responding to patient safety incidents, including investigation, according to their roles,100 with delivery of that training and development from end Q2 2020/21 onwards • eliminate inappropriate performance measures from all dashboards/performance frameworks by Q2 2020/21 • as part of the organisation's quality governance arrangements, monitor on an annual basis the balance of resources for investigation versus improvement and whether actions

¹ Note: This relates to currently available training in the specific skills required to effectively respond to patient safety incidents, particularly investigation skills. Wider work under Involvement to develop and deliver a national patient safety curriculum and training will also incorporate relevant aspects of incident response, including investigation, but local systems should not delay work to ensure their existing staff are skilled to perform the roles they are asked to while the wider curriculum work takes shape.

		<ul style="list-style-type: none"> • develop quality governance arrangements (from Q4 2021/22) that: <ul style="list-style-type: none"> – support implementation and oversight of PSIRF requirements – eliminate inappropriate PSI/SI/patient safety performance measures from all dashboards/performance frameworks – monitor on an annual basis the balance of resources for patient safety incident investigation versus improvement across the local system and whether actions completed in response to patient safety incidents measurably and sustainably reduce risk. 	completed in response to patient safety incidents measurably and sustainably reduce risk.
Implement the medical examiner system	National patient safety team and regional teams	<p>Implement quarterly reporting for medical examiner offices by Q3 2020/21.</p> <p>Facilitate the extension of medical examiner scrutiny from deaths in acute trusts to deaths in non-acute settings, to start Q4 2020/21 and be completed by Q1 2022/23.</p> <p>Establish medical examiner offices in all acute trusts by Q4 2020/21.</p>	<p>Added deliverables at national level.</p> <p>Removed the following as the goal has been achieved:</p> <p>Recruitment of regional medical examiners</p>
	Acute trusts	Ensure deaths in all areas (in non-acute settings as well as acute trusts) are scrutinised by medical examiners by end Q1 2022/23.	Updated timeline.
National clinical review and response, advice and guidance	National patient safety team	<p>Clinical review of and response to reported patient safety incidents, including strategic review of sources, to focus where most new or under-recognised issues are found, and through the publication of NHS England and NHS Improvement National Patient Safety Alerts and activity summaries (Q3 2020/21 and Q1 2021/22).</p> <p>Complete a national patient safety response advisory panel membership review by Q1 2021/22.</p>	<p>Updated objective to be more specific:</p> <p>Original:</p> <p>Ongoing clinical review of and response to patient safety incident reports – including through publishing NHS Improvement Patient Safety Alerts</p> <p>Moved to the safety system section:</p>

		<p>Complete a review of all historical National Patient Safety Agency and NHS England and NHS Improvement alerts to identify any requirements which remain viable beyond their original action date, by Q4 2020/21.</p> <p>Care Quality Commission to begin assessing providers' approaches to ensuring their compliance with the national Patient Safety Alerts as part of its regulatory activity, by Q2 2021/22.</p>	<p>100% compliance declared for all Patient Safety Alerts from Q2 2019/20.</p> <p>Updated objective to replace the following goal which was achieved: Implement the National Patient Safety Alerts Committee (NapSAC).</p>
Agree alignment across ALBs for key shared national patient safety processes	National patient safety team, alert-issuing bodies and CQC	<p>Complete pilot systems for oversight of implementation of HSIB's investigation recommendations:</p> <ul style="list-style-type: none"> • HSIB complete stage one of pilot (assessment of written responses) by Q3 2020/21 • NHS England and NHS Improvement complete remainder of pilot by Q1 2021/22 • Proposals for way forward for future oversight prepared by Q2 2021/22. <p>All relevant ALBs/teams apply to become credentialled issuers of National Patient Safety Alerts by Q1 2021.</p> <p>Procedures for managing exceptional national safety issues that involve multiple ALBs:</p> <ul style="list-style-type: none"> • strategic approach agreed by Q4 2020/21 • operational approach agreed by Q1 2021/22. 	<p>Updated to be more specific and updated timeline.</p> <p>Original: Oversight of implementation of HSIB's investigation recommendations so that 100% are responded to and implemented or alternatives are in place from Q4 2019/20.</p>
Enhance the learning from claims	NHS Resolution	<p>Ensure that development of the new claims management system throughout 2021/22 aligns where possible with PSIMS.</p> <p>Identify the potential for enabling data analysis across established databases (aligning with PSIMS).</p> <p>Deliver an aligned Faculty of Learning to share insight from claims, as part of a search tool to be implemented by Q1 2021/22.</p>	<p>Updated to specify claims (rather than litigation) and add a timeline.</p> <p>Removed as it is NHS Resolution business as usual: Supporting the reduction in maternity incidents via the early notification scheme, CNST incentives, thematic reviews, claims scorecards.</p>

	GIRFT	<p>Produce a litigation data pack for every acute and specialist trust in England by Q4 2020/21. These aim to encourage trusts to review their claims data and learn from claims to improve patient care at a local level. This will continue to include the triangulation with complaints, inquests and serious incidents to maximise learning and the development of interventions to improve patient care.</p> <p>Produce specific documentation best practice guidance in partnership with NHS Resolution, Royal Colleges and specialist societies for five general surgical procedures by Q2 2021/22 and a further five surgical specialties by Q4 2021/22.</p> <p>Publish the first best practice guidance on claims learning for clinicians and managers in collaboration with NHS Resolution by end Q4 2020/21. This will explain to clinicians and managers how to participate in learning from claims and share learning to drive focused improvement.</p>	<p>Updated tasks.</p> <p>Original:</p> <p>Continue programme to support improvements through claims learning including will publishing the first GIRFT best practice guidance on claims learning in orthopaedic surgery, focusing on the high-volume areas of hip and knee arthroplasty during 2019/20.</p>
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Table 4: Involvement objectives

Objective	Who will deliver this	What and by when	Changes from the original deliverables
Patient involvement in patient safety	National patient safety team and patient safety partners	<p>Conclude extended patient safety partners framework consultation and additional series of focus groups by Q3 2020/21.</p> <p>The final framework published in Q1 2021/22.</p>	<p>Updated task and timeline.</p> <p>Original:</p> <p>Patient safety partners framework published by Q4 2019/20.</p>
	Local systems	Local systems and regions aim to include two patient safety partners on their safety-related clinical governance committees	<p>Updated timeline.</p> <p>Original:</p>

		(or equivalents) by Q1 2022/23, and elsewhere as appropriate, and who will have received required training by Q1 2023/24.	Local systems and regions aim to include two patient safety partners on their safety-related clinical governance committees (or equivalents) by April 2021, and elsewhere as appropriate, who will have received required training by April 2022.
Deliver a patient safety curriculum and syllabus that supports patient safety training and education for the whole NHS	HEE, NHS England and NHS Improvement	Publish the final national patient safety syllabus in Q4 2020/21. Review the syllabus content regarding healthcare inequalities.	Removed the following as the goal has been achieved: Evaluate current education and training packages, for inclusion or not in the national patient safety syllabus and create the first national patient safety syllabus by April 2020 Updated timeline.
		Developing a set of quality standards for delivery of the patient safety syllabus by Q1 2021/22 Identification of an accreditation model by Q1 2021/22	Updated task. Removed the following as the goal has been achieved: Develop plans for implementing patient safety training in all relevant training and education
		Make training in the essentials of patient safety available to all staff by Q2 2021/22.	Updated timeline.
	Local systems	Support all staff to receive training in the essentials of patient safety by Q1 2023/24.	No change.

Develop a network of patient safety specialists	National patient safety team	<p>Establish patient safety specialist (PSS) networks at system level by Q4 2020/21.</p> <p>Start distribution of the patient safety update by Q4 2020/21.</p> <p>Identify demographic data for first cohort of PSS and identify if there are equality challenges by Q1 2021/22.</p> <p>Plan for ongoing recruitment and development of a diverse PSS workforce, including support for effective local recruitment practices by Q2 2021/22.</p>	<p>Removed the following as the goal has been achieved:</p> <p>Initial role description available by Q3 2019/20</p> <p>Hold the inaugural patient safety specialist network meeting in Q2 2020/21 (took place in Q3 20/21).</p> <p>Added deliverables.</p>
	Local systems, regional and national healthcare organisations	Identify to the national patient safety team at least one patient safety specialist per organisation by end Q3 2020/21	<p>Updated timeline from:</p> <p>Q4 2019/20.</p>
		Release some patient safety specialists for learning sets as required to inform the development of training by Q1 2021/22.	<p>Updated task.</p> <p>Original:</p> <p>Release patient safety specialists for identified training by Q4 2021/22.</p>
		Deliver training for 750 PSS by Q1 2023/24.	<p>Updated timeline</p>

Table 5: Improvement objectives

Objective	Who will deliver this	What and by when	Changes from the original deliverables
<p>Deliver the Managing Deterioration Safety Improvement Programme (ManDetSIP)</p>	<p>Local systems supported by the national patient safety team and the PSCs</p>	<p>Support the adoption of the COVID-19 oximetry@home and COVID Virtual Ward models across England by Q1 2021/22.</p> <p>Undertake small scale testing of the paediatric early warning score (PEWS) in acute in-patient and ED settings by Q3 2021/22 ahead of scale-up across England.</p> <p>Scale up adoption of deterioration management tools (e.g. NEWS2, RESTORE2, etc.) and reliable personalised care and support planning (PCSP) in non-acute settings across health and social care from Q3 2020/21.</p>	<p>Updated as a distinct national patient safety improvement programme.</p> <p>Original: Deliver NPSIP priorities.</p>
<p>Deliver the Adoption and Spread Safety Improvement Programme (A&S-SIP)</p>	<p>Local systems supported by the national patient safety team and the PSCs</p>	<p>Support the increase in the proportion of patients in acute hospitals receiving every element of the British Thoracic Society chronic obstructive pulmonary disease discharge care bundle for which they are eligible by Q1 2022/23.</p> <p>Support the increase in the proportion of eligible sites (ie acute hospitals in England that care for patients with tracheostomies) adopting three evidence-based tracheostomy safety interventions (bedhead signs, availability of emergency equipment, daily care bundle) by Q1 2021/22.</p> <p>Support organisations to consider designated safe cohort wards for patients with tracheostomies that have trained staff to competently care for these patients by Q1 2021/22.</p> <p>Support the increase in the proportion of patients in acute hospitals receiving every element of the asthma discharge care bundle for which they are eligible, to start Q1 2021/22.</p>	<p>Updated as a distinct national patient safety improvement programme.</p> <p>Original: Deliver NPSIP priorities.</p>

<p>Deliver the Maternity and Neonatal Safety Improvement Programme (MatNeoSIP)</p>	<p>Local maternity systems supported by the MatNeoSIP team</p>	<p>Contribute to the national ambition to increase the proportion of smoke-free pregnancies to 94% or greater by Q1 2023/24.</p> <p>Nationally reduce the rate of stillbirths, neonatal deaths and brain injury by 50% by 2025.</p> <p>Continue to support the spread and adoption of the preterm perinatal optimisation care pathway across England from Q3 2020/21:</p> <p>Improve the early recognition and management of deterioration of women and babies from Q3 2020/21:</p> <ul style="list-style-type: none"> • develop a national pathway approach for the effective management of maternal and neonatal deterioration using the plan/prevention, identification, escalation and response (PIER) framework • work with national stakeholders to develop a national maternal early warning score (MEWS) by Q1 2021/22 ahead of testing and scale-up • support the adoption and spread of the neonatal early warning 'trigger and track' score (NEWTT). 	<p>Updated tasks to include more detail and revised goals.</p>
<p>Deliver the Medication Safety Improvement Programme (MedSIP)</p>	<p>MedSIP national programme team, PSCs and local systems</p>	<p>Reduce medicine administration errors in care homes by completing intervention testing by Q1 2022/23 ahead of scale-up in:</p> <ul style="list-style-type: none"> • safety huddles • learning from errors • managing interruptions • three-way communication. <p>Reduce harm from opioid medicines by reducing high dose prescribing of opioids through scoping and intervention identification by Q1 2022/23, ahead of testing and scale up.</p>	<p>Updated tasks to include more detail and revised goals.</p> <p>Original:</p> <p>The programme will reduce avoidable, medication-related harm in the NHS, focusing on high risk drugs, situations and vulnerable patients. Details to be confirmed.</p>

		<p>Reduce harm by reducing the prescription and supply of oral methotrexate 10mg by Q3 2021/22.</p> <p>Develop a programme to reduce severe harms associated with anticoagulants, which can be delivered from Q1 2022/23.</p> <p>Develop a programme to reduce problematic polypharmacy for the most at-risk populations, which can be delivered from Q1 2023/24.</p>	
<p>Deliver the Mental Health Safety Improvement Programme (MHSIP)</p>	<p>Local systems supported by the MHSIP national programme team</p>	<p>Reduce suicide and deliberate self-harm in inpatient mental health services, healthcare settings and in the healthcare workforce by:</p> <ul style="list-style-type: none"> identifying the interventions that reduce absence without leave (AWOL) and scoping interventions to reduce suicide and deliberate self-harm while on agreed leave by Q1 2021/22 ahead of testing and scale-up scoping the incidence and understanding of suicide and deliberate self-harm in non-mental health acute settings by Q1 2021/22 ahead of testing from Q1 2021/22, support the assessment of ligature anchor points and other environmental self-harm risks for inpatient mental health services. <p>Reduce the incidence of restrictive practice in inpatient mental health and learning disability services by:</p> <ul style="list-style-type: none"> reviewing the interventions and outcomes from the first phase of work by Q1 2021/22 from Q1 2021/22, undertake further testing of the interventions ahead of scale-up across England. <p>Improve the sexual safety of patients and staff on inpatient mental health and learning disability units by developing the change package by Q3 2021/22, ahead of testing and scale-up.</p>	<p>Updated tasks to include more detail and revised goals.</p> <p>Original:</p> <p>MHSIP engagement programme – local systems should develop safety improvement plans post their engagement meeting (unless agreed not needed)’</p> <p>National programme to deliver 33% reduction in restrictive practice in pilot wards by Q4 2019/20.</p> <p>All mental health inpatient providers nominate a ward to participate in the improving sexual safety collaborative. Data collection to be confirmed.</p>

<p>Address safety issues that affect older people</p>	<p>National patient safety team</p>	<p>Align and bring together patient safety improvement initiatives in care homes, including links to the enhanced health in care homes framework and the learning disability improvement standards.</p> <p>Scope the potential for a distinct care homes national patient safety improvement programme (to include work underway on managing deterioration and medicines safety in care homes).</p>	<p>Updated task consolidating initiatives for the national patient safety team. Expanding the breadth and ambition of work in this area.</p> <p>Removed the following goal as it has been achieved in the medicines safety dashboard:</p> <p>Link data on medications and falls.</p>
	<p>NHS England and NHS Improvement Ageing Well team</p>	<p>Produce an anticipatory care framework encompassing the identification of people living with frailty and complex needs, holistic needs assessment and personalised care and support planning by Q1 2021/22.</p> <p>Align work on deterioration of older patients with the managing deterioration safety improvement programme.</p>	<p>Removed the following as the work has concluded:</p> <p>Continue to facilitate the Falls Collaborative Programme and improve falls prevention in hospital through the 2019/20 NHS Commissioning for Quality and Innovation (CQUIN) scheme.</p> <p>Replaced the following by the broader anticipatory care framework:</p> <p>Spread uptake of the electronic frailty index and routine frailty identification and assessment.</p>
	<p>NHS England and NHS Improvement Nursing team</p>	<p>Continue the Stop the Pressure Programme including focus on:</p> <ul style="list-style-type: none"> • reducing health inequalities, understanding the specific issues that relate to pressure ulcers and planning appropriate action by Q2 2022/23 • further development of the evidence base on pressure ulcers • safety improvement in community settings, including an audit on prevalence and clinical care by Q4 2021/22 • improving risk assessment of pressure ulcers by Q4 2021/22. <p>Align work on enhanced health in care homes with the national patient safety team safety improvement work.</p>	<p>Updated to be more specific.</p> <p>Original:</p> <p>Continue the Stop the Pressure Programme.</p>

<p>Address safety issues that affect autistic people and people with a learning disability</p>	<p>NHS England and NHS Improvement supporting local systems</p>	<p>Reduce restrictive Interventions:</p> <ul style="list-style-type: none"> Expand STOMP and STAMP programme to ensure accessible, quality information, regular improved quality medication reviews (at least annually) and access to correct level of monitoring and support to improve quality of life. Publication of segregation and seclusion guidance for CAMHs inpatient care by the Quality Taskforce in 2021 Improvements in data quality of reporting on restrictive practices in 2021. <p>Reduced use and improved quality of inpatient care:</p> <ul style="list-style-type: none"> Ensure implementation and delivery of care, education and treatment (C(E)TR) reviews in line with current C(E) TR policy, and review and refresh current policy by end Q3 2021/22 <p>Reducing health inequalities across the healthcare system:</p> <ul style="list-style-type: none"> Collaborative working with NHS England and NHS Improvement programmes to ensure fair access to mainstream healthcare through Identification of opportunities to collaborate; agreement of joint work plans during 2021 Learning Disability Improvement Standards will be applied to all NHS-commissioned care by 2023/24 Continue to deliver the LeDeR (learning disabilities mortality review) programme including delivery of Restore2 mini project in 2021 to support management of deterioration in health and publication of national LeDeR policy in 2021 Ensure health care services makes reasonable adjustments for people with a learning disability and, or 	<p>Updated to add detail to the original tasks; to better align to Long Term Plan commitments and the work of the Children and Young People Quality Taskforce; and to focus on initiatives that can be aligned with the NatPatSIPS.</p> <p>Original:</p> <p>Accelerate LeDeR and align with the medical examiners system.</p> <p>Expand STOMP and STAMP.</p> <p>Further spread use of care and treatment reviews.</p> <p>All NHS-Commissioned care to meet the learning disability improvement standards by 2023/24.</p>
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		autistic people (in line with Equality Act and Accessible Information Standard) including further development of the Reasonable Adjustments Digital Flag (technical updates to SCRa and piloting of system integration) by end Q3 2021/22	
Deliver the UK National Action Plan for AMR	Local systems, supported by national and regional teams	Local systems should develop plans to: <ul style="list-style-type: none"> • reduce community antibiotic use by 25% (from 2013/14 baseline) by 2024 • reduce use of 'reserve' and 'watch' antibiotics by 10% (from 2017 baseline) by 2024. 	Updated task to focus on targets that remain active. Removed the following: <ul style="list-style-type: none"> • improve the management of lower UTI in older people in all care settings by Q4 2019/20 (supported by CQUIN) • improve antibiotic prophylaxis for colorectal surgery by Q4 2019/20 (supported by CQUIN).
Support patient safety research and innovation	PSTRCs, AHSNs, NIHR, DHSC and the national patient safety team	Publish a summary of patient safety research needs related to the national patient safety strategy, including need for new technical solutions to Never Events and needs related to patient safety health inequalities, by Q4 2020/21. Submit any identified needs that are appropriate for policy research to the Department of Health and Social Care policy research stream, by Q1 2021/22. Identify opportunities to incorporate patient safety research needs in existing centres and funding streams.	Updated task and timelines. Original: Develop new technical solutions to Never Events Support the safety innovation pipeline more widely.

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