Safety First Recommendations

Number	Recommendation	National or Trust Action Required	Existing Measures/Action Required (Trust)
1	As the next round of national goals, priorities and targets are being established from the period from 2008, it is important that the NHS takes steps to ensure that patient safety is further deeply embedded as a core principle that underpins those priorities.	National	Not applicable
2	The Department of Health should establish a National Patient Safety Forum, jointly chaired by the Chief Executive of the NHS and the Chief Medical Officer, to harness the skills and expertise of a number or organisations, agencies and stakeholders which are making a significant contribution to patient safety.	National	Not applicable but Trust may be approached to contribute at a later date.
3	The National Patient Safety Forum should oversee the design and implementation of a national patient safety campaign-focused initiative. The objective of this initiative should be to engage, inform and motivate clinical staff and healthcare providers to address the challenge of providing safer healthcare.	National – however the Trust may be required to pledge their commitment to patient safety.	Will be responsible for participating in campaign/initiative

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4	The role of the National Patient Safety Agency (NPSA) should be refocused on its core objectives of collecting and analysing patients safety data to inform rapid patient safety learning, priority setting and coordinated activity across the NHS. A number of current functions, for example the development of technical solutions to improve patient safety, presently delivered by the organisation should in future be commissioned from other expert organisations with the requisite expertise.	National	Not applicable
5	The one purpose of the National Reporting and Learning System (NRLS) should be to identify sources of risk and harm to patients which can be acted upon at local and national level. The present NRLS should be redesigned to make it more effective in this respect, including simplifying and encouraging reporting as well as including a new category of analysing risk prone situations and anticipating adverse events. PCTS should take account of the information and learning available locally from the NRLS in commissioning services. Locally – required to develop strategies to encourage reporting. Near misses and a new category of 'adverse events that could happen' should also be reported. Reports should be confidential but not anonymous.	National and Trust	Locally incident form and categories under review and includes adverse events that could happen. Incident forms are not anonymous.

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6	The Patient Safety Management function currently delivered by the NPSA should be hosted by strategic health authorities (SHAs), and recast as 'Patient Safety Action Teams' to support the delivery of the national patient safety agenda by local NHS organisations. The team should consist of experts with skills in data analysis, incident investigation and solution development.	SHA	Will be required to work with Patient Safety Action.
7	Prime responsibility for incident investigations should reside with local NHS organisations. Every NHS organisation should have access to a specialist investigator based within the Patient Safety Action Team. All reports should be considered locally within 24 hours or being reported. The NPSA should be notified of all events that involve serious patient harm and death within 36 hours of the initial report. NHS organisations should be encouraged to draw on different sources of data, such as complaints, claims and coroners' reports, to ensure that all deaths and serious harm associated with adverse events are identified.	Trust	Not currently achievable with paper based system however this should be achievable when electronic form is available (April 07) Complaints and Litigation use the same database as Risk Management. Close liaison between Risk Management and Litigation regarding Coroners' reports and another required medical information.

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8	Accountability for patient safety rests with the Chair and Board of each NHS organisation. Each Board should therefore be expected to outline how it intends to discharge this responsibility. Importantly, each Board should also make clear how it intends to ensure that patients and carers play an integral part in all initiatives to introduce a patient safety culture change within the NHS.	Trust	There is an Assurance Framework and patient representatives on the Assurance Committee which informs the Board, further work required.
9	The approach of the Healthcare Commission in monitoring progress in patient safety should be further developed into a high-profile programme which comprehensively monitors and assesses progress against national and local standards and indicators of performance. PCTs should be accountable for ensuring that all providers used by their patients have effective patient safety reporting systems and are implementing technical solutions satisfactorily.	PCT – will required trust to have effective reporting system	Each Director is responsible for maintaining and monitoring the Healthcare Commission core and developmental standards. This progress is mapped and held centrally. PCT representative member of Clinical Governance Committee. Trust response to SABs monitored on a monthly basis.
10	A pilot should be established to examine the option of the National Institute for Health and Clinical Excellence (NICE) developing technical patient safety solutions.	National	Not applicable
11	The NHS Institute for Innovation and Improvement should be asked to work with the medical Royal Colleges and other educational providers to ensure that advances are made in education and training to support patient safety.	National	The Trust will provide information as required.
12	All NHS organisations should develop and implement local initiatives to promote greater openness with patients and their families when things go wrong and provide required support.	Local (with National guidance)	Will implement when specific guidelines available. At present Patient Relations help and support clinicians if meetings with families are required.

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13	The active involvement of patients and their families should be promoted by establishing a national network of patient champions who will work in partnership with NHS organisations and other key players to improve patient safety; the network should also have strong links with WHO World Alliance for Patient Safety's 'Patients for Patient Safety' initiative.	National	Will provide information and establish links when required.

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14	• The development of an overall project plan to ensure the delivery of all key recommendations – this should be discussed at the first meeting of the National Patient Safety Forum • An inaugural meeting of the National Patient Safety Forum is to take place in early 2007 • With expert input, redesigning the National Reporting and Learning System in order to have a re-engineered system launched in 2007. • An early pilot to determine if NICE can effectively deliver technical solutions with a decision in early 2007. • Immediate action to establish Patient Safety Action Teams. • There is a need to clarify roles and responsibilities both within the Department and in the NHS for the delivery of the Patient Safety Agenda. • The imperative to improve patient safety will need to be taken into account as a central component of the Health Reform Agenda. It is therefore important that an ongoing dialogue takes place with the Healthcare Commission, Monitor and other regulators.	National	