Sheffield Teaching Hospitals
NHS Foundation Trust

Executive Summary

Report to the Trust Board of Directors

Held on 25 January 2022

Subject	National Patient Safety Strategy Implementation Plan
Supporting TEG Member	Jennifer Hill, Medical Director (Operations)
Author	Sue Butler, Head of Patient and Healthcare Governance Lisa Howlett, Deputy Head of Patient and Healthcare Governance Rebecca Nadin, Patient Safety Manager
Status[1]	Approval

PURPOSE OF THE REPORT

To brief the Trust Board of Directors on timeframes and actions required to implement the requirements of the National Patient Safety Strategy.

KEY POINTS

The National Patient Safety Strategy (NPSS) was published in July 2019. Since then, work has been on-going nationally and locally to progress implementation of key priorities.

Locally, implementation is expected to be delivered through new Patient Safety Specialists (PSSs) within each organisation. STH PSSs have been in place and participating in NHS England / Improvement NPSS implementation briefings since October 2020.

There are seven key objectives within the NPSS and the Trust is well placed to implement these within national timeframes. Of the seven objectives:

- One objective (National Patient Safety Alerts) has already been successfully implemented.
- Two objectives (Quality of Incident Reporting and Learning from National Patient Safety Events) are underway with no concerns regarding implementation.
- Two objectives (National Patient Safety Syllabus and Just Culture) are medium concern. Whilst the Trust is in a good position for implementation, there are challenges anticipated including capacity to release staff for training.
- Two objectives (Patient Safety Partners and Patient Safety Incident Response Framework) are higher concern due to the scale of change involved and the resource required to implement this. Resource requirements are in the process of being identified for preparation of a Business Case.

Implementation plans for NPSS objectives are being developed and priorities have been identified. A NPSS Task and Finish Group is to be established to operationally manage implementation the Safety and Risk Committee will oversee progress and a quarterly assurance report will be provided to the Healthcare Governance Committee.

IMPLICATIONS[2]

Aim of the STHFT Corporate Strategy		✓ **Tick as appropriate**
1	Deliver the Best Clinical Outcomes	✓
2	Provide Patient Centred Services	✓
3	Employ Caring and Cared for Staff	
4	Spend Public Money Wisely	
5	Deliver Excellent Research, Education & Innovation	
6	Create a Sustainable Organisation	

RECOMMENDATIONS

The Trust Board of Directors is asked to note plans for implementation and to approve proposed arrangements for oversight.

APPROVAL PROCESS

Meeting	Date	Approved Y/N
TEG	12/01/2022	Y
HCGC	17/01/2022	Y
Public Board	25/01/2022	

[1] Status: A = Approval
A* = Approval & Requiring Board Approval
D = Debate
N = Note

[2] Against the six aims of the STHFT Corporate Strategy 'Making a Difference – The next Chapter 2022-27'

1. Introduction

The National Patient Safety Strategy (NPSS) which was published in July 2019, sets out what the NHS will do to achieve its vision to continuously improve patient safety in line with three strategic aims:

- Improving understanding of safety (**insight**),
- Equipping patients, staff and partners with the skills and opportunities to improve patient safety (**involvement**)
- Designing and supporting programmes that deliver effective and sustainable change (**improvement)**.

The Strategy set out the high level direction of travel and in the intervening period work has been undertaken nationally, to pilot some areas of the strategy and develop guidance, frameworks, and seminars to support implementation.

Locally, implementation is expected to be delivered through new Patient Safety Specialists (Appendix 1) within each organisation and earlier in the year a set of priority objectives were identified.
This paper summarises the NPSS seven key objectives, Trust plans for implementation, areas of potential concern, and proposals for delivery and oversight within existing structures.

2. Key NPSS Changes

The key changes introduced by the Patient Safety Strategy are:

- The introduction of ***patient safety specialists*** into all organisations. The aim of this role is to ensure that there are key individuals in each organisation who, with the support of the Board, provide leadership and expertise in relation to patient safety (see appendix 1). All provider organisations were required to identify PSSs by November 2020 and for STH the role is shared across a number of individuals; Deputy Medical Director with responsibility for patient safety, the Head and Deputy Head of Patient and Healthcare Governance, and the Patient Safety Manager. Since October 2020, Trust PSSs have been participating in regular national briefings hosted by NHS England/Improvement.

- Embedding ***just culture*** principles in the way that the Trust operates to ensure psychological safety for staff. Ensuring that these principles are reflected in HR policies and practice supports a culture of fairness, openness and learning by making staff feel confident to speak up when things go wrong rather than fearing blame. This cycle then promotes a positive safety culture. Organisations are expected to evidence **on-going** progress in embedding just culture principles and whilst there is clear support across the Trust for just culture principles, further work is required to ensure and evidence that these are fully embedded and consistently applied across the organisation.

- Ensuring that within organisations there is a consistent, centrally co-ordinated response to ***National Patient Safety Alerts.*** This approach ensures that the required action is taken in all relevant areas of the organisation, embedding national learning to protect patients from harm. The Trust process for the management of NPSAs is in line with national requirements and is well embedded. Since Q1 2021/22, closed alerts are reported quarterly via the Integrated Quality and Safety Report.

- Take action to improve the ***quality of incident reporting***, ensuring the accuracy of data to support local and national learning, ensuring that action is focused in the most effective way. Organisations are expected to evidence on-going progress, including actions to increase incident reporting rates. The Trust has a positive incident reporting culture and benchmarks well nationally for incident reporting rates. Work is planned to further increase incident reporting focussing on directorates and staff groups where reporting rates are lower.

- Improving the way patient safety information is structured, collected and used across the NHS through the introduction of a new ***learning from patient safety events (LFPSE)*** ***system*** which will replace the current National Reporting and Learning System (NRLS) and Strategic Executive Information System (StEIS). This will require the Trust to make significant changes to our Risk Management System (Datix) to meet the new national reporting requirements by mid-2022. Trust's

risk management system provider (Datix) has confirmed that the system will be upgraded to ensure full implementation of the LFPSE in line with national requirements and timescales.

- Implement a new ***Patient Safety Incident Response Framework*** which will supersede the current Serious Incident Framework ensuring that high quality, systems-based incident investigations are undertaken by individuals with the capability, capacity and seniority to affect change. Final PSIRF guidance will be published in **Spring 2022** when all providers are expected to begin to transition to PSIRF. Fully meeting the requirements of PSIRF presents a significant challenge and will require changes to both structures and processes for incident management. PSIRF will mean fewer, better quality in-depth investigations and the introduction of a range of approaches to respond to incidents not subject to full investigation, which in turn requires staff with appropriate capacity and capabilities.

- Implement the national ***Framework for Involving Patients in Patient Safety*** to promote the voice of patients through the involvement of patients in their own safety and the recruitment and ongoing support for patient safety partners (patients or lay people who contribute to organisation's governance and management processes to support patient safety). By June 2022, organisations are required to have two Patient Safety Partners on the organisation's '*'main clinical governance committee"*. This will be followed by roll out of PSPs across other relevant groups and workstreams. In addition, organisations are required to progress programmes of work to increase patient involvement in their own safety. Capacity to implement, embed and support Patient Safety Partners is challenging and work has commenced to agree an implementation plan and to prepare a Business Case, in line with national guidance.

- Create a shared understanding of safety through delivery of staff training and education as defined by the ***national patient safety syllabus*** (appendix 3). Level 1 and Level 2 training have now been made available nationally and following the Patient Safety Specialist briefing in December 2021 a Training Needs Outline and implementation plan will be developed.

A more detailed gap analysis against each NPSS objective, along with actions required to meet the milestones is provided in Appendix 2.

3. Implementation

Governance arrangements for delivery of the work are proposed as follows:

- The Executive with lead responsibility for delivery of the NPSS is the Medical Director (Operations)
- A Senior Lead has been identified with responsibility for leading the operational implementation of each NPSS objective and these are detailed in the gap analysis in Appendix 2.
- The Trust PSSs will form a NPSS Task and Finish Group which will meet monthly and will involve other key senior staff as required. These will include the Trust's Patient Experience Manager and Learning and Development Manager.
- The Safety and Risk Committee will oversee progress via bi-monthly reports from the NPSS Task and Finish Group commencing in January 2021.
- Quarterly progress reports will be provided to the Healthcare Governance Committee, who will oversee implementation on behalf of the Board.

Implementation will initially focus on priority objectives. These are:

- Transition to PSIRF
- Implementation of Patient Safety Partners
- Completion of a TNO for levels 1 and 2 of the national patient safety syllabus training

4. Conclusion

The Trust is in a strong position to deliver the majority of the requirements of the patient safety strategy within the required timescales. Two objectives present considerable challenge due to the scale of change required and resource to support this. A business case is being developed to seek additional

resource to support implementation of PSPs and a detailed plan is being prepared for implementation of PSIRF.

The Trust Board of Directors is asked to note plans for implementation and to approve the proposed arrangements for oversight of delivery.

Appendix 1

Patient Safety Specialist Role Summary

The national PSS communications toolkit describes the role as follows:

These individuals are the lead patient safety experts in their organisations, working full time on patient safety (in some organisations the role may be shared).

Patient safety specialists provide leadership, visibility and expert support to the patient safety work within their organisation. They 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 their 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 may 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.

The national PSS role outline includes:

- Responsibility for/oversight of the implementation of the NHS patient safety strategy within the organisation
- Ensuring that there is a robust and effective patient safety strategy in place which aligns with the NHS patient safety strategy.
- Influence and have direct access to the executive team.
- Promote patient safety insight as an approach that incorporates understanding all sources of patient safety intelligence.
- Ensure information and intelligence is used as the basis for prioritising local patient safety development and proposed improvement approaches are based on an understanding of underlying causes
- Support / lead multi-professional responses to patient safety incidents, tailoring the different approaches required for new or under-recognised issues and wider patient safety challenges needing long-term improvement.
- Lead / support the development of a patient involvement strategy in patient safety including the recruitment and collaborative working with patient safety partners.
- Work in networks with Patient Safety Specialists from other organisations to share good practice and learn from each other

National Patient Safety Strategy Priorities 2021/22

Gap Analysis

The Trust's position against each priority has been RAG rated based on the level of concern in relation to ability to ensure full implementation within national timeframes.

National requirements	Current position	Actions required	Deadline	Lead
Patient Safety Specialists (National timescale November 2020 then on-going)				
Identify a PSS and notify NHS E/I by November 2020.	The Trust identified three Patient Safety Specialists by the national deadline: - Sue Butler, Head of Patient and Healthcare Governance - Simon Buckley, Deputy Medical Director - Rebecca Nadin, Patient Safety Manager Since October 2020, the Trust's PSSs have been participating in regular PSS briefings and networking events hosted by NHS E/I. In October 2021, Lisa Howlett, Deputy Head of Patient and Healthcare Governance became the Trust's fourth Patient Safety Specialist.	A national generic PSS role outline has been produced and we therefore need to: - Undertake a stocktake and review of our PSS approach /model to ensure it is appropriate - Clarify how PSS responsibilities will be shared - Agree a role description for the STH PSS role, based on the national generic role.	31 January 2022	Head of PHG
Identify Executive PSS support Identify an Executive lead for patient safety as a direct contact point for PSS and a NED lead for patient safety. The executive lead should ensure that there is: • A PSS workplan based on national priorities for delivery of the NPSS • Sufficient resource and support for PSSs to complete the requirements of their role including patient safety training to level 5 of the Patient Safety Syllabus once available	Executive Lead for patient safety is Jennifer Hill, Medical Director (Operations). Non-Executive Director lead is Ros Roughton, Healthcare Governance Committee Chair.	The implementation plan for the NPSS will form the work plan for the PSS.	31 Oct 2021	Head of PHG

National requirements	Current position	Actions required	Deadline	Lead
Communicate and raise awareness of the PSS role and National Patient Safety Strategy priorities All Board members should be aware of and support the PSS's role and discuss as a Board agenda item.	This paper will be presented to the Board of Directors on 25th January 2022. A copy of the national executive briefing document is attached as appendix 4. The NPSS priorities and the PSS role have been informally communicated through governance networks and meetings across the Trust. These include the Safety and Risk Forum.	Agree a communications plan, making use of the national communications toolkit and presentation slides.	31 January 2022	Head of PHG
Just Culture (National timescale: on-going)				
Embed the principles of a safety culture on an ongoing basis. The Trust should ensure that: - The Just Culture Guide is formally adopted and built into your organisation's HR policies; and that staff and staff representatives understand how and when it should be used - Ensure the safety sections of the NHS Staff Survey results are reviewed and discussed, and agree any actions needed to improve patient safety culture.	The Just Culture guide has been formally adopted and is an integral part of the Incident Management Policy. Currently not specifically referenced within relevant HR policies and this needs to be reviewed. Staff survey results published in March 2021 and included within the quarterly IQSR. Overarching results for safety questions suggest Trust is above average (6.9 vs 6.8). Key opportunities for improvement are: • Organisation takes action in response to incidents (STH 75.3%, group average 72.7%, group best 84.2%) • Staff receive feedback (STH 62.0%, group average 61.9%, group best 72.6%) Work already identified includes a review of a sample of responses provided via Datix to staff who have reported incidents.	Complete a review of relevant HR policies to ensure alignment with Just Culture principles and incorporate a specific statement regarding Just Culture. Build into relevant staff training.	31 March 2022	Asst. Head of Employee relations
		Agree specific actions in relation to national staff survey safety questions.	31 January 2022	Patient Safety Manager
		Pilot the SCORE safety culture survey tool within theatres to support longer term culture change.	31 March 2022	Deputy Medical Director

National requirements	Current position	Actions required	Deadline	Lead
National Patient Safety Alerts (NatPSAs) (National timescale December 2019)				
Ensure that there is a system for the receipt and actioning of NatPSAs by December 2019. The system must ensure that: - There is an organisational-wide coordination of response, with executive oversight, led by appropriate senior healthcare professional(s). - the board is notified as new NatPSAs are issued; and the appropriate people are involved to ensure actions are completed in the identified timescale. - NatPSAs are only recorded as 'action completed' on CAS with executive authorisation and assurance that all actions are complete.	Management of the Central Alert System (CAS) and the Onward Distribution and Action of Safety Alerts Policy in place, but due for review. On receipt of a NatPSA the Medical Director (Operations) is notified and appropriate senior leads are identified to respond to the alert. Alerts are only closed following approval from the lead Executive Director. Data show all PSAs in the last 12 months were closed within timeframe. On-going compliance is reported quarterly via the new IQSR.	Complete review of policy to incorporate national changes.	31 Dec 2021	Occupational Safety Manager

National requirements	Current position	Actions required	Deadline	Lead
Improving quality of patient safety incident reporting (National timescale: on-going)				
Improve the quality of incident reporting - Use your organisation's NRLS explorer reports to help improve how incidents are captured locally and most effectively described to the board. - Ensure quality of information recorded in local incident reports, including degree of harm.	Latest data shows that the Trust's level of incident reporting is in the expected range. However there is scope to increase reporting and this has been further highlighted through recent SIs which have been identified through complaints. The Safety Message for June 2021 promoted incident reporting. Further work, including targeted work with specific directorates, is being planned. For maternity CQC suggested that grading of incidents did not match the actual harm to patient or staff member. A subsequent review by the CCG showed high levels of consistency between staff assessment and CCG of the level of harm recorded.	Identify and implement actions to improve incident reporting. Actions already identified include: • Review feedback provided via Datix to staff who report incidents • Complete an audit of the reporting of falls as incidents • Follow up specific cases where an incident has not been reported and is highlighted via other routes such as complaints, to identify learning • Review incident reporting including reporting rates by directorate • Agree a process/rolling programme for data quality review including levels of harm	31 March 2022 31 January 2022 From August 2021, on-going 31 January 2022 31 January 2022	Head of PHG/Patient Safety Manager
Transition from NRLS and STEIS to Learn from Patient Safety Events (National timescale: mid-2022)				
Ensure organisational readiness for transition to the national Learn from Patient Safety Events (LFPSE) (previously known as PSIMs) Feedback from a national briefing held on 28th July indicates that: - The national timescale for roll-out is mid-2022. - The new reporting process will require a number of additional fields in our incident reporting form. - Uploads will be fully automated.	Datix have confirmed that they are working in line with the national rollout timeline to ensure that all Datix organisations (including those using DatixWeb) are equipped and able to report to the LFPSE.	Alert Safety and Risk Committee to the expected changes. Develop implementation plan once DatixWeb is compliant with national requirements. Internal communications plan to be developed.	31 January 2022 Full implementation by mid-2022. 31 January 2022	Patient Safety Manager Patient Safety Manager Patient Safety Manager

National requirements	Current position	Actions required	Deadline	Lead
Transition to the new Patient Safety Incident Response Framework (National Timescale Spring 2022)				
Prepare for implementation of the PSIRF This should be informed by nationally shared early adopter experience. Initially local systems should: • 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 are equipped to respond to patient safety incidents as described in the PSIRF: ○ Update quality governance arrangements (from Q4 2021/22) to support implementation and oversight of PSIRF requirements	It is expected that the final PSIRF will be launched nationally in Spring 2022. The new Deputy Head of Patient and Healthcare Governance has previously led PSIRF at an early adopter site and has been identified as the Trust lead for PSIRF, supported by the Patient Safety Manager. The Trust has an embedded process for initial review and check and challenge for pressure ulcer incidents and this is being further developed to include falls. In Maternity a Rapid Review process is in place, to support immediate actions, learning and escalation as required. Whilst the Trust has in place robust processes for incident management, PSIRF represents a significant change and requires the introduction of new approaches to incident management.	Complete a gap analysis against the introductory version of the PSIRF and supporting guidance, in particular the Patient Safety Incident Investigation Standards for presentation to the Safety and Risk Committee	31 January 2022	Deputy Head of PHG/ Patient Safety Manager
Implement the Framework for Involving Patients in Patient Safety (National timescale June 2022)				
The **framework for involving patients** was published 30 June 2021. Expectations include: • Board commitment to Patient Safety Partners including a public statement • Develop a business case to secure adequate financial resources to support the involvement of PSPs • Two PSPs on the organisation's ''main Clinical Governance Committee'' by June 2022	The Trust has a strong culture of patient and public involvement which is a good foundation for this work. It has been indicated nationally that the work is likely to require additional resource to manage the programme of work which includes PSP recruitment and selection, induction and training, objectives/appraisal, expenses, and measuring and evaluating impact. There will need to be agreement as to which is the relevant committee that the two PSPs sit on. National wording is ''main Clinical Governance Committee'' which is likely to be the Trust's Healthcare Governance Committee.	Complete a gap analysis against the PSP framework and develop an implementation plan.	31 January 2022	Deputy Head PHG/Patient Experience Manager
		Business case to be developed in response to gap analysis.	31 January 2022	Deputy Head of PHG/ Patient Experience Manager

National requirements	Current position	Actions required	Deadline	Lead
Patient safety education and training (National timescale: April 2023)				
Support all staff to receive training in the foundations of patient safety by April 2023, including: - Ensuring Executive directors with responsibility for patient safety and education and training are aware of the patient safety syllabus, and the requirements for all staff to be trained. - Develop of an implementation plan with the relevant education and training teams for the delivery of 'essentials' training once available in July 2021. - Monitor the uptake of 'essentials' training across the organisation	Level one and two learning materials will be available on the E Learning for Health platform from autumn 2021: - level 1 (essentials) e-learning modules which are aimed at all staff - level 1 (essentials) e-learning module for Boards and Senior Leadership teams - level 2 (access to practice) – for those who wish to progress further	Develop a training needs outline for delivery of essential training and an implementation plan to be approved at Safety and Risk Committee.	31 January 2022	Deputy Head of L&D/ Patient Safety Manager
		Implement 4-monthly reporting of uptake via Safety and Risk reports to Safety and Risk Committee	To commence Feb 2022	Patient Safety Manager

Patient Safety Syllabus Summary

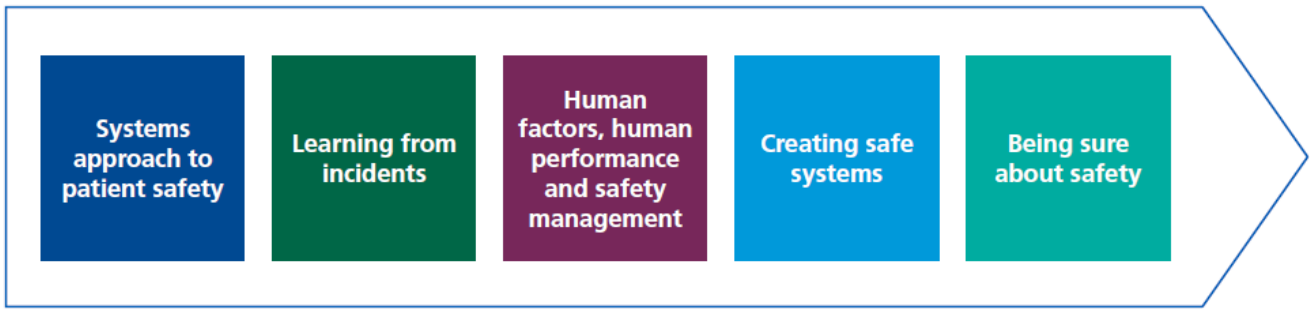
One of the priorities within the Patient Safety Strategy published in July 2019 was the development of an NHS-wide Patient Safety Syllabus which would support a transformation in patient safety education and training in the NHS. The Patient Safety Strategy included ambitions to develop training in the fundamentals of patient safety that would be relevant to all NHS staff – clinical and non-clinical – as well as more detailed training and education that could be incorporated into clinical and non-clinical undergraduate and postgraduate healthcare education and continuing professional development.

The Academy of Medical Royal Colleges has worked with the University of Warwick to develop a syllabus which is designed for all NHS staff and is structured to provide both a technical understanding of safety in complex systems and a suite of tools and approaches that will:
Build safety for patients
Reduce the risks created by systems and practices
Develop a genuine culture of patient safety.

Structure

The syllabus is descriptive rather than prescriptive, based on five sequential domains, drawn from developing themes in patient safety,

Figure 1. Key Domains in the Patient safety syllabus



In addition, the following four key themes of underpinning knowledge and expertise run through all of the domains:

- Systems thinking
- Human factors
- Risk expertise
- Safety culture.

Implementation

The syllabus is now being used as the basis for the preparation of detailed curricula and training modules, designed for specific levels of the NHS. The timeline for delivery of educational materials is as follows:

- Level 1 (Essentials) Patient Safety Syllabus educational materials are currently being developed for all staff and are due to be launched later summer. These consist of:
    - Essentials introductory video (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, in autumn 2021
- Levels 3-5: higher level modules for those in patient safety roles to be available by March 2022

Patient safety specialists

Formally creating this role provides status and the expectation that having a patient safety specialist(s) who is fully trained in the national patient safety syllabus is standard across the NHS

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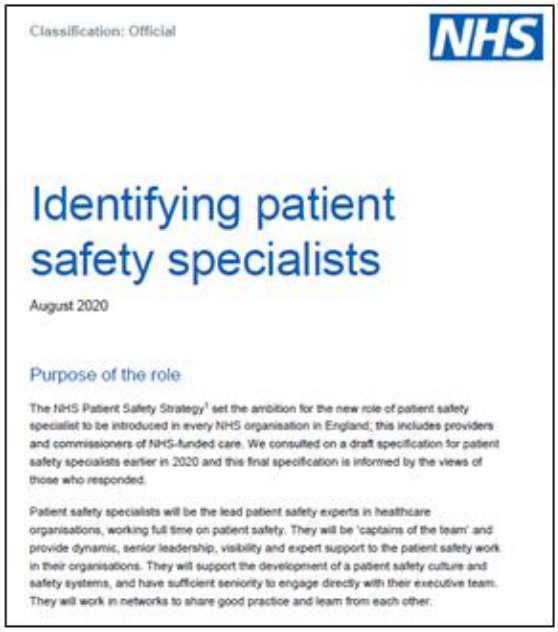

Classification: Official

NHS

Identifying patient safety specialists

August 2020

Purpose of the role

The NHS Patient Safety Strategy[1] set the ambition for the new role of patient safety specialist to be introduced in every NHS organisation in England; this includes providers and commissioners of NHS-funded care. We consulted on a draft specification for patient safety specialists earlier in 2020 and this final specification is informed by the views of those who responded.

Patient safety specialists will be the lead patient safety experts in healthcare organisations, working full time on patient safety. They will be 'captains of the team' and provide dynamic, senior leadership, visibility and expert support to the patient safety work in their organisations. They will support the development of a patient safety culture and safety systems, and have sufficient seniority to engage directly with their executive team. They will work in networks to share good practice and learn from each other.

Patient safety specialist role

NHS

- Lead patient safety experts in their organisation, working full time on patient safety
- Able to escalate immediate risks or issues to Exec team
- 'Captains of the team', provide dynamic senior leadership, visibility and expert support
- Work with others including: Medication safety officer (MSO), Medical device safety officer (MDSO), Maternity safety champions
- Lead /support the local implementation of the NHS patient safety strategy: insight, involvement and improvement
- Support the development of a patient safety culture and safety systems
- Work in networks to share and learn
- Lead, and may directly support, patient safety improvement activity
- Ensure that systems thinking, and just culture principles are embedded
- Support patient safety partners (Framework for involving patients in patient safety)
- Learn and develop, complete the Patient safety syllabus

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Key deliverables

- 2019 - Role identified as part of the NHS patient safety strategy
- 2020 Mar - Patient safety specialists made a contractual requirement within the NHS Standard Contract 2021/22 section 33.7
- 2020 Aug/Nov - Identifying Patient Safety Specialists and providing nominations to NHSEI from every NHS organisation by 3011/20
- 2020 Nov – National webinars provided to support patient safety specialist training
- 2021 Apr – patient safety specialists to be full time in post
- 2021 Apr – patient safety specialist priorities document provided
- 2021 Jun - Patient safety syllabus available for patient safety specialists and training for the Board

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Early milestones

- Over 700 Patient Safety Specialists representing 96% coverage of relevant organisations
- We have held 16 national meetings – topics including:
  - National patient safety improvement programmes
  - Views on patient safety culture
  - PSIRF progress update
- Involvement in two national safety issues:
  - Beckton Dickinson infusion devices
  - Phillips device recall
- Involvement in national working groups including:
  - National Patient Safety Syllabus
  - Development of NHSX digital strategy
- Development of FutureNHS Collaboration platform (access via patientsafetyspecialists.info@nhs.net)
- Patient safety priorities document provided
- Starting to create region and ICS patient safety specialist networks

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PSS priorities

- Just culture support and advice
- National Patient Safety Alerts advice
- Improving quality of incident recording
- Support transition from NRLS and StEIS to the new Learn from patient safety events (LFPSE) service
- Preparation for implementing the new Patient Safety Incident Response Framework (PSIRF) when it is launched in 2022
- Implementation of the Framework for involving patients in patient safety (published in June 2021)
- Patient safety education and training including the first two levels of the Patient safety syllabus launched in summer 2021
- Supporting involvement in the National Patient Safety Improvement Programmes, working with local AHSNs and Patient Safety Collaboratives
- COVID-19 recovery support – more information will be provided shortly

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Executive PSS support requirements

1. The Patient Safety Specialist was required to be identified by Apr-21. The expectation is 1FTE at band 8 range, but this may be a shared role, or more than 1FTE across large organisations
2. The PSS's name(s) has been provided to NHSEI by executive lead for patient safety
3. An executive lead for patient safety should be identified as the direct contact point for the PSS. The PSS should also link with the NED who leads on patient safety.
4. All Board members should be aware of and support the PSS's role and discuss as a board agenda item
5. The PSS priorities document (circulated Apr-21) should be reviewed and a PSS work plan agreed with the patient safety executive lead
6. The PSS should be provided with sufficient time and resources to undertake their role, network and complete the patient safety training requirements (to level 5 of the Patient safety syllabus once available)
7. There should be sufficient support/ coaching / mentoring in place for the PSS to progress their personal and leadership development

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