Birmingham East and North NHS
Primary Care Trust

ATTACHMENT 4.2

PATIENT SAFETY REPORT

Purpose

The purpose of this paper is to outline the proposed structure of a monthly Patient Safety Report, commencing October 2008, to be submitted to the Integrated Governance and Performance Committee and to be reported to the PCT Board for information or discussion as appropriate.

Context

Nationally, the profile and importance given to patient safety has never been higher and is set to continue to rise. The Healthcare Commission has signalled it's intention to focus greater attention on assurance underpinning patient safety and has indicated a particular interest in Board time dedicated to this theme.

In *High Quality Care For All - NHS Next Stage Review Final Report*, the document highlighted the requirement that quality must be at the heart of everything that we do and understood from the perspective of patients. "The first dimension of quality must be that we do no harm to patients. This means ensuring the environment is safe and clean, reducing avoidable harm such as excessive drug errors or rates of healthcare associated infections".

In 2006, the Department of Health published *Safety First, A report for patients, clinicians and healthcare managers* in which the Department's Chief Medical Officer (CMO) indicated that the pace of change to improve patient safety in the NHS was too slow despite the publication of *An Organisation with a Memory* in 2000. The CMO felt unable to assure NHS patients that all organisations were learning from experience in ways that prevent harm to patients. This included all developed countries and was not unique to the NHS. He suggested that that most countries recognised that they had for too long failed to give priority to patient safety compared to other areas of healthcare. Four major themes were highlighted:

- The importance of implementing systems and interventions that actively and continuously reduce risks to patients. Harm to patients should not be viewed as an acceptable part of modern healthcare
- The need to quickly respond to errors and risks so that their effects on patients and healthcare workers can be quickly mitigated.
- The need to encourage and support competent, conscientious and safety-conscious health workers in front line services by creating an environment that motivates and inspires them to make care as safe as possible.
- The need for strong leadership at the top of all healthcare organisations and for safety to be seen as a priority.

Birmingham East and North PCT recognises the delivery of quality safe services as a core purpose. This is reflected in the PCT's commissioning vision to 'improve safety, quality, effectiveness and efficiency of services'.

Reporting Framework
A wide range of PCT activities support, promote and assure patient safety. These activities, in turn, generate a range of information flows. It is proposed that these information flows should be collated each month into a single 'Patient Safety Report'. The document will report progress against PCT strategies that underpin patient safety including both the BEN PCT and Health Economy Prevention and Control of Infection Plans and the Patient Safety Strategy that is currently in development.

It is proposed that infection prevention and control (IPC) and serious untoward incidents (SUIs) will feature in each monthly report and that other activities will be reported according to an agreed schedule.

The framework below represents the key activities that underpin patient safety enabling delivery against an organisational objective where assurance and improvement of patient safety is core to the PCT business. The reporting framework will centre around three key themes of:

Theme 1: Leadership for Patient Safety
This will include reporting on activity demonstrating organisational commitment to the visibility of leadership for patient safety. Building and strengthening a patient safety culture including evidence of changes in practice in response to lessons learned along with the further development of patient safety systems will be reported. Continuing to provide a culture of supporting and encouraging staff to provide safe services and to report risks and incidents.

Theme 2: Patient safety information and intelligence
This will focus on reporting incidents where things have gone wrong or have the potential to go wrong. Identified themes and trends will be reported along with actions plans and follow up reports related to improvements required.

Theme 3: Improvement of Patient Safety
This theme will focus on integration of risk management activity relating to patient safety and the development of systems and processes to identify and manage key risks. Further involvement of patients and the public in issues of patient safety and particularly in developing safer services will be reported. The development of improvement capability for patient safety and implementation of solutions will also be included.

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