

Safer Systems for a Safer NHS

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NPSA Report

- Commissioned 2004 by Deputy Chief Medical Officer (DCMO)
- Conducted by NPSA Risk Advisor

Report Findings

- Not identifying safety as a benefit to drive the programme
- No formal risk assessment
- No formal safety management system
- Reliance on clinicians to instinctively address patient safety problems

Report Conclusion

- NPfIT not addressing safety in structured, proactive manner and other safety critical industries would

Action Taken

- Appointment of National Clinical Safety Officer (seconded from NPSA)
- Implementation of Clinical Safety Management System (CSMS)
- Adoption of principles of IEC 61508
 - Patient Safety Assessment
 - Safety Case
 - Safety Closure Report
- Accredited clinician training
- Governance Structure
 - Clinical Safety Group (fortnightly)
 - Clinical Risk and Safety Meeting (monthly)
 - Clinical Risk and Safety Board (quarterly)

On-going work

- Safer IT products
- Clinical Risk Reduction
- Safer Implementation

Safer IT Products

- Clinical risk management system administered through Clinical Safety Group
- Required documentation
- Certificate of Authority to Release (CATR)
- Safety incident management process

Clinical Risk Reduction

- Right patient right care (safe management of blood products; NHS number, wristband dataset)
- Safer prescribing (alerts; 'top 10' unsafe drugs)
- Safer handover (scoping; dataset development)

Safer implementation

- High-level strategy
- Safe implementation toolkit

Recent Developments

- Appointment of Chief Clinical Officer
- Development of new Health IT Standard
- Development of patient safety policy
- Refinement of safety incident management process and procedure

Second NPSA Report

- Major findings
 - pro-active actions and progress made by NHS CFH to put in place systems and processes to address patient safety in the NPfIT in an explicit, proactive, structured and robust manner
 - Gaps (opportunities for further improvement) where further development will enhance the effectiveness and efficiency of the NPfIT helping the NHS realise patient safety benefits
 - Recommendations for NHS CFH's consideration, aimed at realising the opportunities for improvement identified.
- On-going improvement opportunities

Conclusion

- Considerable movement from 'standing start' 2 years ago
- Major workstreams underway
- Still early days
- Nevertheless, probably world leading work on safety in Health IT