Join us to help improve patient safety

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The publication of the Francis report has seen a renewed focus on improving patient safety for all who contribute to the healthcare agenda – from politicians, senior decision makers and commissioners to those delivering clinical care at the front line.

Patient safety is more than reporting adverse incidents. The Francis report and Don Berwick's safety work provide recommendations which include the need to change culture around safety, legislation for a duty of candour on NHS organisations to ensure openness when things go wrong and a national safety programme to spread good practice.

The Editorial Board of *Infant* journal is very keen to be part of supporting these safety priorities. In particular, in raising awareness of specific issues which affect our population and staff. With this in mind the Board have agreed to devote a specific section to patient safety in each edition of the journal. This will be a one-page feature which might take several forms:

- Using the journal as one of many vehicles to inform readers about forthcoming relevant alerts; trends as seen through the National Reporting and Learning System; national patient safety programmes/days/weeks/events etc
- Improvement programmes at national level which improve patient safety
- Improvement programmes at local, regional or national level which have enhanced safety
- National work programmes which are being planned which will reduce morbidity through safety strategies
- Local sharing of incidents and lessons learned, submitted as anonymised, short articles by clinicians (nursing and medical)
- Human factors for consideration in learning from safety incidents
- Patient narratives on their experiences of care which might improve safety.

This range of articles means that we can all work together to improve safety through the journal, which will be the first of its kind to do this! Anyone can submit an article and the above list is not exhaustive so if you have ideas for highlighting other safety aspects to improve care, please do let us know.

There will need to be careful governance around how best to share learning from incidents so as to protect individuals and the public who have been involved. It will be imperative to maintain anonymisation at all levels (patient, Trust etc). The Board are therefore delighted to be undertaking this as a joint collaboration with BAPM who have existing governance processes in place for reviewing and selecting incidents which have relevance for wider learning. This will support a streamlined approach to developing a national safety culture within maternity and neonates through BAPM and *Infant* journal.

Our first article in the July issue will focus on the new alerting system launched in January 2014 by the patient safety domain in NHS England who has replaced the pre-existing National Patient Safety Agency (NPSA).

Next steps: Think about how you might be able to contribute to improving patient safety through *Infant* journal. Have you implemented an initiative locally which has demonstrable benefits for improving safety? Are you developing a new initiative which might benefit from a wider application? Sharing this more widely early on might improve the pilot phase, garner interest and refine the project design. Do you have experience in any human factors-related improvement which you'd be able to share?

If you would like to submit a patient safety article to *Infant*, please email lisa@infantgrapevine.co.uk
If you have any incidents for national learning, please contact BAPM by emailing bapm@rcpch.ac.uk

Did you know... ?

General principle

The government's initial response to the Francis report in February 2013 included the introduction of a new hospital inspection regime and legislation for a duty of candour on NHS organisations, so they have to be open with families and patients when things go wrong.

Actions on safety and openness include[1]:

- transparent, monthly reporting of ward-by-ward staffing levels and other safety measures
- quarterly reporting of complaints data and lessons learned by Trusts along with better reporting of safety incidents
- a statutory duty of candour on providers, and professional duty of candour on individuals
- a new national patient safety programme across England to spread best practice and build safety skills across the country and 5,000 patient safety fellows who will be trained and appointed within five years
- Trust liability if they have not been open with a patient
- a dedicated hospital safety website to be developed for the public.

Reference

1. **DH.** *Francis report on Mid Staffs: Government Accepts Recommendations.* [Online]2013. Available from: www.gov.uk/government/news/francis-report-on-mid-staffs-government-accepts-recommendations. [Accessed 7 April 2014].