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Trusts: Lack of time and staff mean safety alerts go unaddressed

By Matt Discombe | 28 January 2020

Trusts blame lack of time and capacity for not implementing safety alerts

Also cite lack of national guidance, staff changes and restructure, according to report shared with *HSJ*

Concern over how trusts deal with "known" patient safety risks

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Trusts have blamed a lack of time and staff capacity for long delays in implementing national safety alerts, according to a report shared with *HSJ.*

NHS organisations told Action Against Medical Accidents that lack of staff capacity and tight timeframes were the most common reasons why national patient safety alerts had not been implemented years after the deadline set for them.

A report written from the group by David Cousins, former head of safe medication practice at the National Patient Safety Agency and NHS England, says trusts have also blamed staff changes and mergers, administration errors, and lack of national standards, when asked for the reasons alerts had not been implemented.

Safety alerts going unimplemented locally is a well-known problem, and data for March last year showed there were 64 instances of non-compliance with national patient safety alert deadlines — which are issued by NHS Improvement — across 44 trusts. The missed alerts told trusts to act on issues such as misplaced tubing, medication, equipment and introducing national safety standards for invasive procedures – one alert had not been implemented by a trust more than five years past its deadline.

Mr Cousins told *HSJ* the reasons most commonly cited by trusts were time and staffing. His report will be published later today.

One trust told Avma, in response to a Freedom of Information request, that its reasons for delays included "available resources, capacity, need for business case approval, reliance on external guidance" and delays in national codes of practice being published.

Another trust said a literature review mandated in one patient safety alert "took longer than expected due to this being performed in addition to the lead's clinical responsibilities".

As of March, Dartford and Gravesham Trust had not complied with five patient safety alerts – the most of any trust in England. The trust told *HSJ* it had now closed two of the outstanding alerts, and one further alert will close at the end of this month.

Avma is calling for the Care Quality Commission to more closely monitor trusts which do not comply with national safety alerts, and 'chase' and act against providers which miss deadlines by long periods of time or don't comply with multiple alerts.

Avma chief executive Peter Walsh said: "We are grateful to David Cousins, a well-known patient safety expert, for this hard hitting and timely report. The recommendations should be acted upon by the NHS and Care Quality Commission. If it is serious about patient safety the NHS must be an organisation with a memory."

Archived alerts

The report also says a ‘bottom-up’ approach by NHS Improvement to deal with long-term safety risks – leaving individual trusts to form their own solutions – could mean over-stretched providers have inconsistent standards and ‘post code patient safety’.

It also raises concern about alerts which are “archived”, or are classed as “known” or “wicked” risks. These often date back many years, and are no longer subject to fresh alerts to the system from NHSI.

Some 75 of the 137 patient safety alerts issued since 2002 are classed as “archived”, have not been updated since the National Patient Safety Agency website was archived in April 2012, which means there is “uncertainty” about the status of these risks, Avma says.

NHSI’s patient safety strategy says new alerts are “inappropriate” for “wicked” problems, as they are too complex to be addressed in this way. NHSI has previously said it wants to “empower front line staff to make decisions about the best way to improve patient safety”.

But Mr Cousins, an independent safe medication practice consultant, and advisor for Avma, told *HSJ* there should be greater transparency about this category of risks, and what trusts should do about them.

He said: “The worry that I have [about what he said was a bottom up approach to these risks] is that we have postcode patient safety.

“One hospital might focus on something, but it’s not transferred throughout the system. There are different levels of patient safety throughout the system. Shouldn’t there be a national standard for patient safety that patients should expect when they go to hospital?

“Let’s have some transparency about whether these ‘known’ risks are getting worse or better.

“There needs to be a top down approach as well as a bottom up approach. There needs to be clarity about what these known risks are, and guidance so there is not duplication all the time.”

NHSE said alerts were best suited to reducing harm from new and emerging risks, where clear actions can be communicated, but were not effective for well-known risks. Others were addressed in patient safety improvement programmes, it said. A spokesman said: “We expect providers to comply with all national patient safety alerts, on top of continually working to tackle known and longstanding risks.

“As well as improved CQC oversight of alert compliance, the draft NHS standard contract will give local commissioners more power to take action where an alert is not complied with.”

Source

Avma report, interview with David Cousins

Source Date

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