# Editorial

Peter Walsh, Chief Executive

One of the biggest changes we will see as a result of the NHS reforms in England is the demise of the National Patient Safety Agency (NPSA). Once a source of admiration, if not envy, from colleagues around the world who are passionate about patient safety, the NPSA is due to be abolished by the end of March 2012. However, as we go to press, it appears that it will barely be functioning from as early as April 2011. Whilst the NPSA has not universally been loved, there is no denying the passion and quality of many of the staff it attracted and the value of its focus on patient safety and nothing else, something that will be sorely missed. I would like to take this opportunity to discuss the legacy of the NPSA, how some of its most important work might be carried forward in the new system, and what is happening in the meantime.

Taking these in reverse order, it is staggering how politicians can get carried away with their long term vision and fail to consider the immediate short term. Whatever one thinks about the overall direction of travel, there is a need to maintain an ongoing vigilant approach to patient safety in the transition period. This appears simply not to have been considered. Not only is the NPSA barely functional (it issued its last ever patient safety alert in March, and says it won't be available to answer queries about the existing ones from April), but of course we are also due to lose primary care trusts (PCTs) and strategic health authorities (SHAs). These bodies also have an important role to play in overseeing patient safety locally and regionally. Many of them have already been losing staff and are in disarray. At a meeting about the new Health Bill, I asked a minister what the business plan for patient safety was in the interim period. His answer was "what a good question, I will consult colleagues and we will get back to you". They never did. I also asked why the Bill was being put through Parliament now, before plans could benefit from the findings of the Stafford public inquiry. There was a pause, and then "good point, we will review the Bill before it completes its passage through Parliament and make any necessary amendments in the light of the inquiry". You can just picture that can't you? A Minister standing up in the Commons and agreeing to substantial changes at an advanced stage of their own Bill for which they have already argued passionately.

The longer term plan is for some of the functions of the NPSA to eventually be taken up by the new NHS Commissioning Board. However, this body will not formally exist until Spring 2012, and how long it will take to be fully functioning is anyone's guess. The word is that what resource does transfer from the current NPSA budget, is also likely to be a third or even less of what it is now. Sitting patient safety work nationally within the NHS Commissioning Board might end up being a good thing. One of the major criticisms of the NPSA was that it lacked clout. The Board will have clout, but there are clearly good grounds to be concerned that, in effect, patient safety work could be diluted or be less of a priority, given the many responsibilities of the Board. And even more cause for concern about patient safety in the interim.

What are the most important parts of the NPSA to take forward? From what we understand so far, the safest element is the National Reporting and Learning System (NRLS). I have always felt that whilst a reporting system is clearly important, far too much emphasis has been put on collecting data at the expense of actual solution/prevention work. What is actually the output we are looking for from reports? Surely it is learning what most often goes wrong and causes harm, how this can be avoided, getting that information out to the service, and making sure that it is acted upon? On the face of it we currently have a system that does just that. The NPSA identifies the issues that need to be the subject of a "patient safety alert". These are sent to all trusts with a specific set of required actions that it is meant to be compulsory for all trusts to complete by a specific deadline. Perfect, in theory. However, AvMA's research on the implementation of patient safety alerts has shown that trusts do not all take these alerts seriously, and the regulators seem remarkably relaxed even about trusts who have multiple alerts outstanding, including alerts that are literally years past the deadline! We need the system of learning and issuing alerts continued, but a challenge to the NHS Commissioning Board will be to use its clout to ensure that they are actually implemented on time. Peoples' lives depend on it.



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