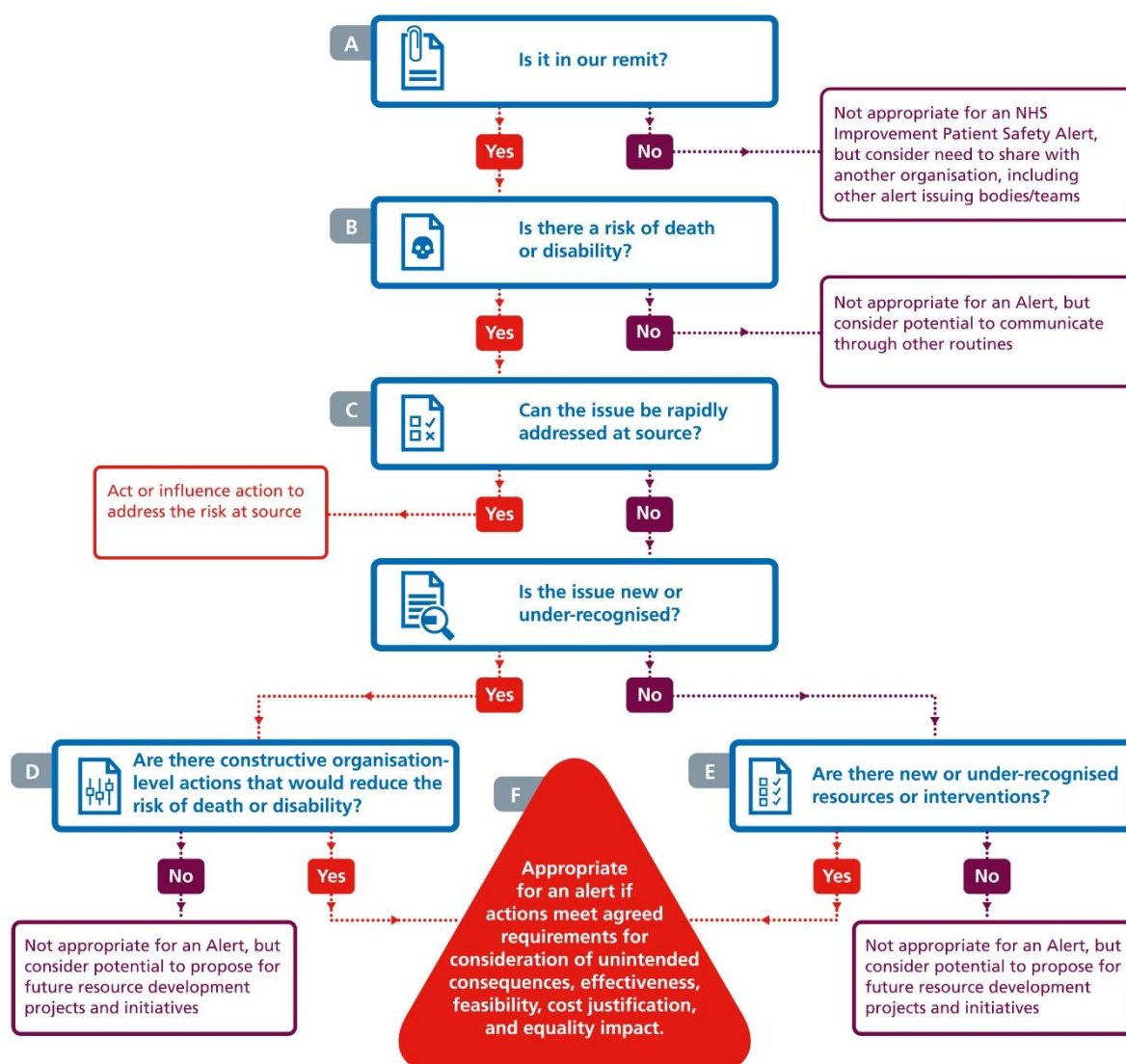


## Deciding if the patient safety issue, resources or intervention meet the criteria for an NHS Improvement Patient Safety Alert



- A. NHS Improvement's Patient Safety Alert remit is defined as "when systemic actions can be taken to prevent or reduce errors of omission or commission by healthcare staff".
- B. Agreed by NaPSAC as "more likely than not one or more potentially avoidable deaths or disability in healthcare per 50 million population in the following year".
- C. An example of addressing an issue at source is manufacturers of medical equipment or IT systems changing their design in such a way that it eliminates the risk of error.
- D. To be constructive, actions must do more than raise awareness or warn people to be vigilant against error. They require healthcare organisations to take systemic action, not actions that are more effectively delivered by professional organisations such as royal colleges.
- E. 'Resources and interventions' can include new technology or new networks or collaboratives, as well as more traditional resource sets. To support an Alert, they must do more than describe correct care and additionally help to systemically reduce the risk of error.
- F. As defined by NaPSAC – see <https://www.england.nhs.uk/patient-safety/national-patient-safety-alerting-committee/>