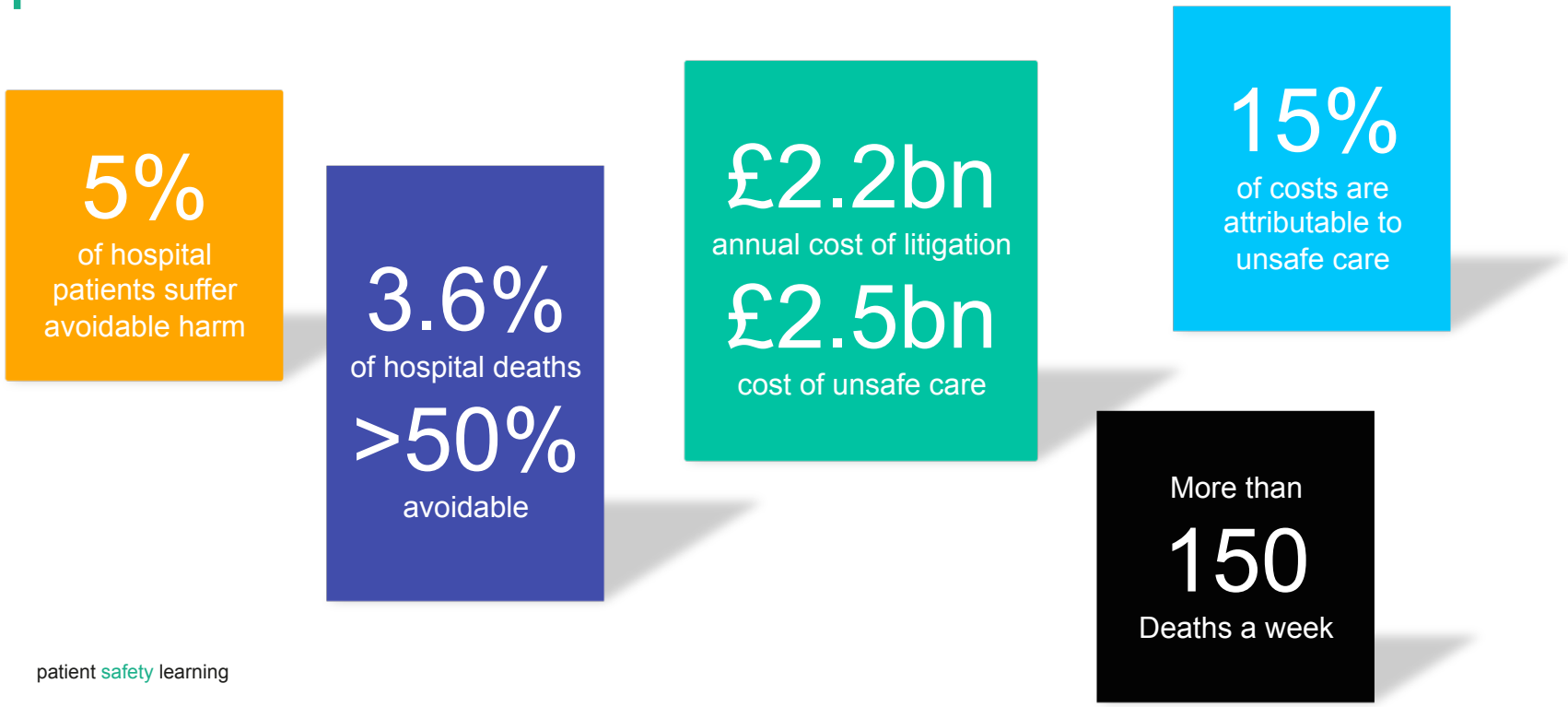
Taking action for a patient-safe future

Helen Hughes
Chief Executive

patient safety learning

20 years of initiatives but still too many patients suffer harm



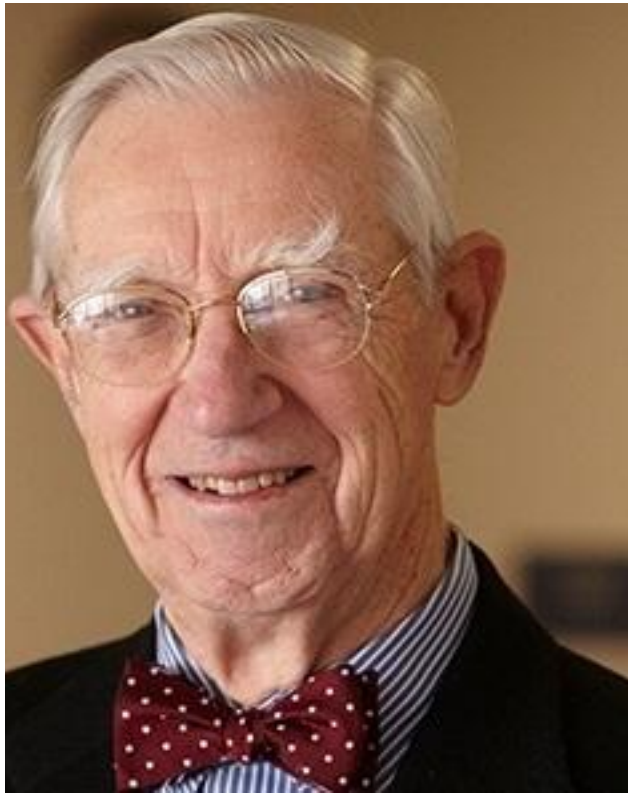
Why is patient harm a persistent problem?

- A failure to learn
- Few safety standards, not consistently applied
- Implementation gap
- Not designing safe systems with human factors
- Lack of leadership for safety
- Staff are not provided with safety skills & knowledge
- Patients are not engaged in their safety
- Poor data and reporting
- Blame culture and fear

Blame doesn't make us safe

- The single greatest impediment to error prevention in the medical industry is *“that we punish people for making mistakes.”* Professor Lucian Leape

- 2017 NHS Staff Survey found that only 45% of NHS staff believe that their organisation treats people fairly after a safety incident



CQC Opening the Door to Change, 2018

"The current patient safety landscape is confused and complex, with no clear understanding of how it is organised or who is responsible for what tasks."

We need to map who does what and coordinate for patient safety. We need clear leadership

Unsafe care has systemic causes

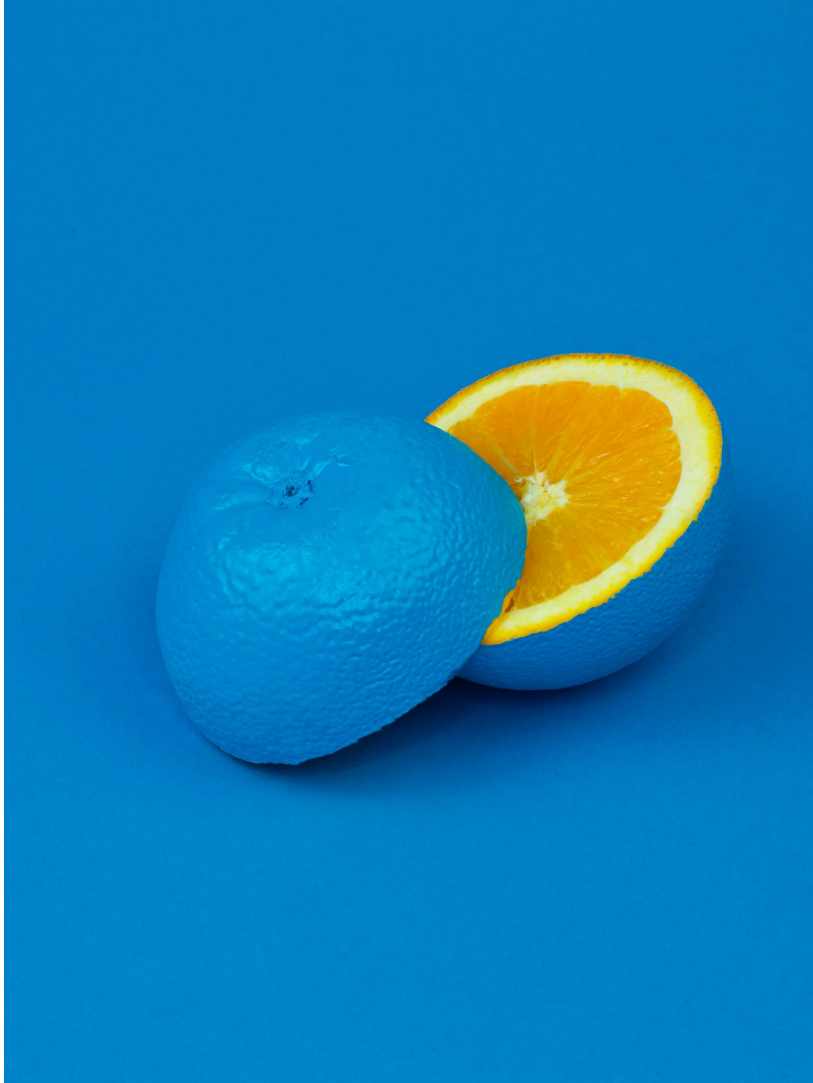
Systems issues and human factors

- Who made the decision and why?
- Was there a patient safety risk assessment?
- Were staffing levels assessed and changed?
- Impact on culture?
- Would an SUI investigation identify this as a cause?
- What would you do? Who would you tell?

Who could fix this? Who should?

- The Anesthetist?
- The surgical team/Directorate??
- The Board?
- Medical or Nursing Director?
- Chief Operation Officer?
- Risk manager/Patient Safety Manager?
- Commissioners/funders?
- CQC/Professional bodies/Royal Colleges?

We need to think and act differently about patient safety.



patient safety learning

Design for safety - not just addressing harm

- Systems and human factors approaches
  - Actively seek out safety problems
  - Design for safety - not just addressing harm
- Make it safe for staff
  - To deliver safer care
  - To work in health care
- Patients and the public as partners in safety
- We use of technology for safer care
- We share learning

What will a patient-safe future look like?

A patient-safe future: patient safety is a core purpose

- Learning is shared and applied quickly and easily
- We set standards
- Take ‘all reasonable & practical steps’
- Staff are suitably qualified & experienced for safety
- Patients are members of the team
- Better measurement & reporting
- A culture that prizes safety and promotes learning

We aim to help people think differently about patient safety.

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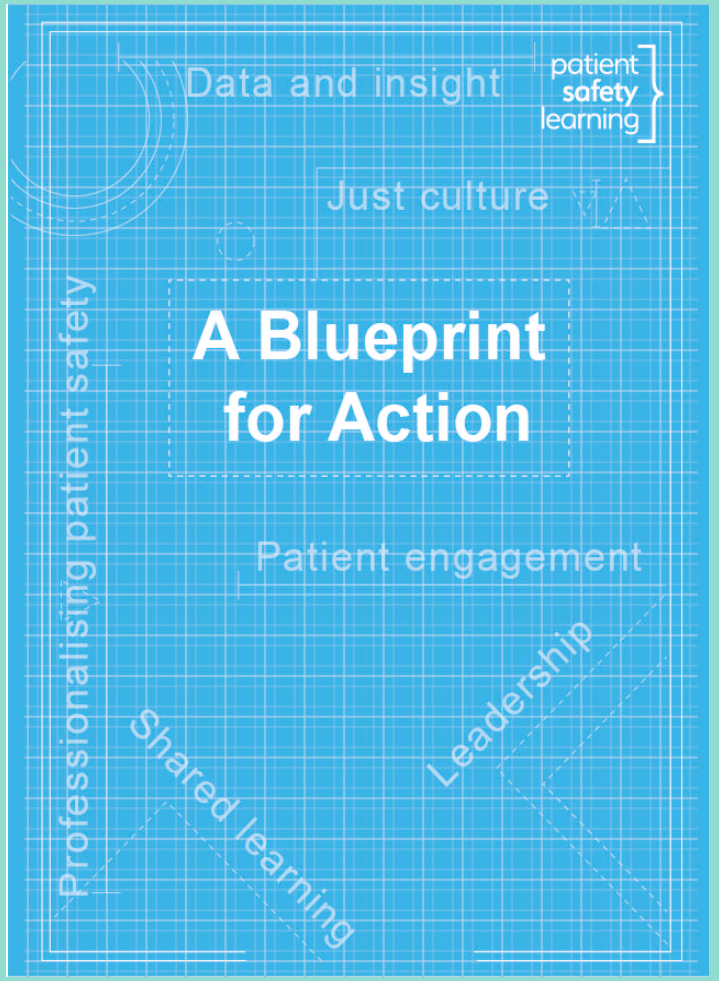
A Patient-Safe Future

A Patient Safety Learning
Green Paper

September 2018



A patient-safe future

A Blueprint for Action

Shared Learning

"To err is human, to cover up is Unforgiveable and to fail to learn is inexcusable."

Sir Liam Donaldson

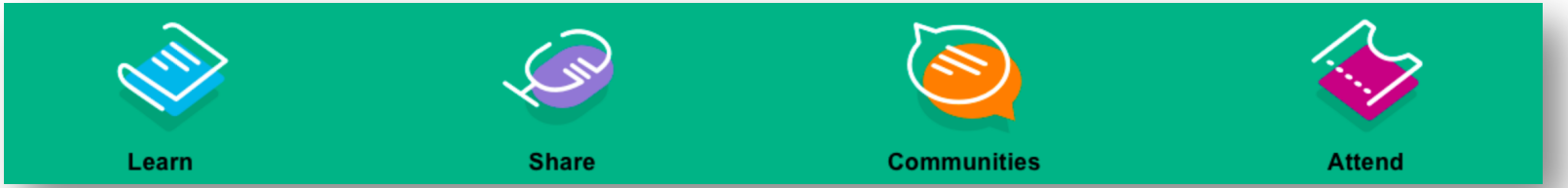
- We need organisation to have goals to share learning
- We share knowledge & innovation readily
- We need to be able find answers to questions
- We have access to proven tools and resources

the hub: an online platform for learning

- For clinicians, PS leads, researchers & patients
- Repository of tools, case studies & good practice
- Communities
- Patient safety news and stories
- Events
- Free to use

the hub's emerging platform structure

patient safety learning } *the hub*



- Learn something
- Share knowledge
- View/ join a conversation
- Sign up for an event

Professionalise patient safety

- Standards for patient safety
- A competency framework for all staff
- Patient safety & human factors expertise
- Investigations for learning and prevention
- ‘Implementation gap’

L*eadership* for safer care

- A strategic *purpose*
- Patient safety goals, standards and metrics
- Forum of leaders with clear roles
- Effective governance and oversight
- Patient safety management system
- Design safety into integrated care systems

E*ngage patients* for patient safety

Patient engagement improves care and safety

- At the point of care; training and support for staff
- ‘When things go wrong
  - Patient harm care pathways’ for patients, families & staff
  - In investigations
- Patient advocacy with support & governance
- Holding the system to account

Data and insight
How do we know if we are safe?

- Safety comparison data to drive out variation
- Patient safety dashboards
  - Quantitative
  - Qualitative including stories and case studies
- Symposium of experts and users

Replace blame culture with a *Just Culture*

- We must eradicate blame and fear
- Programmes to eliminate a blame culture and introduce or deepen a Just Culture
- Measure and report progress
- Leaders model the behaviour we want to see

Work in partnership for a patient-safe future

- Health and social care commissioners and providers
- System and professional regulators
- Policy makers
- Parents and families
- Politicians
- Professional associations
- Clinical leaders
- Patient charities
- Safety system and human Factors experts
- Researchers

Help create a patient-safe future

- Tackle the blame culture
- Support the patient-safe future proposals
- Share learning and contribute to *the hub*
- Lead for patient safety

What questions do you have?

- helen@patientsafetylearning.org
- www.patientsafetylearning.org
- info@patientsafetylearning.org

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Board patient safety self-assessment matrix

- New tool in development
- Assess against the patient safe future foundations
- To identify where more should be done
- Concise version of the matrix

The task

- Assess your organisation
  - Try to identify a document, policy, system or behaviour that you have seen in your organisation that illustrates your assessment
  - What you would like to see but haven’t yet done so
- Identify whether you have enough knowledge
- Identify what action you might want to take
- Discuss in groups and feedback

Rating guide/Assessment Level	Level 0 Minimal	Level 1 Reactive	Level 2 Active	Level 3 Proactive	Level 4 Safety is a core purpose
Overall organisational assessment for patient safety (Using Patient Safety Learning's six foundations for a Patient-Safe Future)	Aiming to follow statutory and regulatory requirements for patient safety Designated leadership roles for Patient Safety at Board level	Plans in place to meet statutory and regulatory requirements for patient safety Focus on response to harm by reporting incidents and undertaking investigations	Meeting statutory and regulatory requirements for patient safety Actively seeking opportunities to improve patient safety including the foundations for a patient-safe future	Plans in place to improve patient safety including the foundations for a patient-safe future Evaluated evidence of improvements in reducing harm and supporting staff deliver safer care	Patient Safety is embedded in all organisational policies and objectives A demonstrable safety culture Partnership for patient safety across the health and social care systems