### Towards a Patient-Safe Future

### A Blueprint for Action

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patient safety learning

We aim to help people think differently about patient safety



## 20 years of initiatives but still too many patients suffer harm

More than

150

Deaths a week

5%

of hospital patients suffer avoidable harm

3.6% of hospital deaths

>50%
avoidable

15%

attributable to unsafe care

of costs are

£2.2bn

annual cost of litigation

£2.5bn

cost of unsafe care

### Why is patient harm a persistent problem?

- Safety is a priority but one of many
- A failure to learn: from unsafe care and excellent care
- Few safety standards, not consistently applied
- Not designing safe systems with human factors
- Blame culture and fear
- Patients are not engaged in their safety
- Lack of leadership for safety

### 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 - a forum of leaders



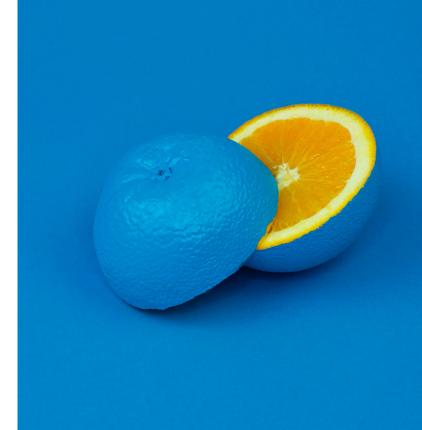
# Unsafe care has systemic causes



### 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 is responsible for fixing this?

We need to think and act differently about patient safety



### New ways of thinking and action for safety

- Design for safety
  - Actively seek out safety problems
  - Implement good practice
  - Re-design using systems and human factors
- Culture make it safe for staff
- Patients as partners
- Better use of technology
- Share learning

# What will a patient-safe future look like?



### In a patient-safe future

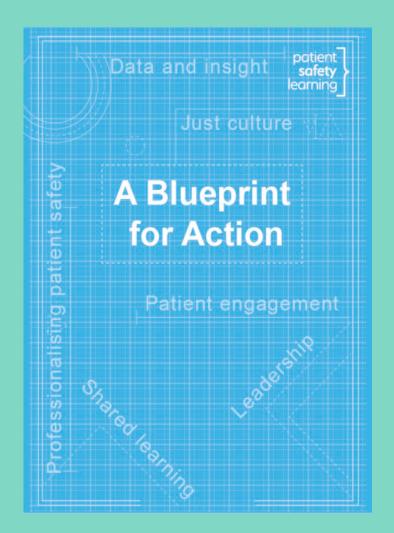
- Patient Safety is a core purpose
- Learning is shared and applied quickly and easily
- There are standards for patient safety
- All staff are suitably qualified & experienced for safety
- Patients are members of the team
- Better measurement & reporting
- A culture that prizes safety and promotes learning

patient safety learning

#### A Patient-Safe Future

A Patient Safety Learning Green Paper

September 2018



# Foundations for a patient-safe future



### Shared learning

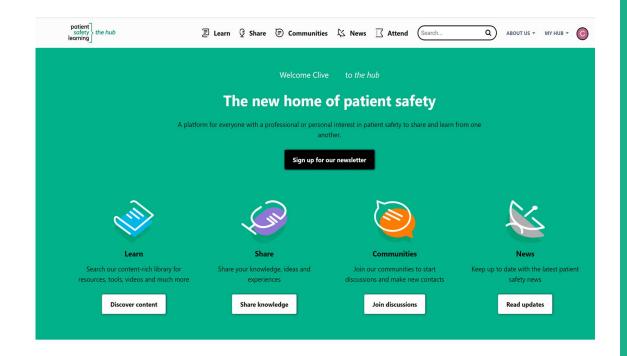


"To err is human, to cover up is unforgiveable and to fail to learn is inexcusable" - Sir Liam Donaldson

- Goals to share learning: from harm, near misses, good practice, patients feedback and complaints
- Share knowledge & innovation readily
- Find answers to questions
- Access to proven tools and resources



- For everyone
- Free for use



patient safety learning

### Professionalise patient safety



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

### Leadership for safer care



- Patient Safety is a strategic purpose
- Patient safety goals, standards and metrics
- Forum of leaders and governance
- Design for safety not just respond to harm
- Design safety into integrated care systems

### Engage patients for patient safety



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

## Data and insight to understand if and how 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
- 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

### Work with us to create a patient-safe future

- Support our patient-safe future proposals
- Engage with us on the hub
  - Provide content
  - Join a community
  - Share learning
  - Become a topic expert
  - Share your experiences from the 'front line'

### What questions do you have?

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