#### Towards a Patient-Safe Future

#### Leadership for Patient Safety

Helen Hughes Chief Executive





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?

- 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
- Safety is a priority but one of many

#### CQC's '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



## 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



#### We need a roadmap



- Roles and responsibilities of organisations and within organisations
- Where are the gaps and overlaps?
- What should system leadership look like?

#### New ways of thinking and action for safety

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

#### Leadership for safer care



The standard you walk past is the standard you accept Gen David Hurley 2013

There is a strong link between the safety of services and the quality of leadership CQC 2018

# What will a patient-safe future look like?



#### In a patient-safe future:

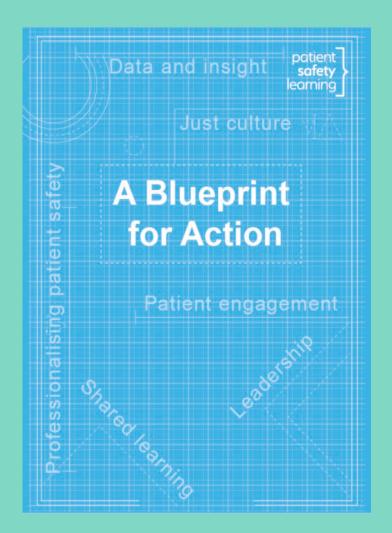
- Learning is shared and applied quickly and easily
- There are standards for patient safety
- All staff are suitably qualified & experienced for safety
- Patients are members of the team
- Better measurement & reporting
- A culture that prizes safety and promotes learning
- Patient Safety is a core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

patient safety learning

#### A Patient-Safe Future

A Patient Safety Learning Green Paper

September 2018



## Foundations for a patient-safe future



#### Framework and common standards



- Fire Safety
  - Standards
  - Guidance on implementation, competencies, management, reporting, audit and regulation
  - Exemplar fire safety management systems with roles, competencies, responsibilities, policies, protocols
- It's not yet there but is needed for patient safety

#### 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
- Leadership behaviours

#### Tools for leadership for patient safety

- Board patient safety self-assessment matrix
- Accreditation for patient safety
- Leadership behaviours and culture change
- Replace blame culture with a Just Culture
  - Programmes to eliminate a blame culture
  - Measure and report progress
  - Leaders model the behaviour we want to see

patient safety learning

#### Board self-assessment model



patient safety learning

#### Board self-assessment matrix (extract)

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

patient safety learning

#### 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?

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

