

Just Culture

Data and insight

patient
safety
learning

Patient engagement

Patient Safety Learning's six foundations for safe care

Based on
The Patient-Safe Future:
A Blueprint for Action

Professionalising patient safety

Shared learning

Leadership

Patient safety is a strategic purpose

Health and social care organisations have many strategic priorities. If patient safety is considered as one of these strategic priorities, weighed against others, with organisations and individuals then deciding which take precedence, patient safety then becomes a matter of choice.

We think it wrong that safety is negotiable. We believe that organisations need to demonstrate that they are taking 'all reasonable and practical steps' to deliver safe care.

patient
safety
learning

If we are to achieve a patient-safe future, patient safety must be more than a priority for an organisation. It must be core to its purpose, reflected in everything it does.

In a patient-safe future, we will see patient safety as part of the purpose of health and social care:

- organisations take responsibility for patient safety and treat it as a systems issue, owned by their leaders, patient safety experts, all clinicians and support staff.
- health and social care organisations measure how safe they are so they can take corrective action.
- organisations establish decision-making processes that demand explicit, evidence-based assessment of the impact on patient safety, selecting the option that offers the safest outcome for patients or explaining why.
- health and social care initiatives explicitly include a positive impact on patient safety as an objective. They also include preventive actions to mitigate risks to patient safety.
- strategies for patient safety are woven through every aspect of any plan for health or social care; a plan for health or social care is a plan for patient safety.

In our report, *A Blueprint for Action*, we discuss in more detail why patient safety needs to be a strategic purpose of health and care, and go on to examine systemic causes of patient safety failure. Based on our research, we identify six evidence-based foundations for safer care and practical actions to address them. You can [download the full report on our website](#).

In the rest of this document, we lay out our six foundations for safer care under three section headings: we analyse the current landscape; describe what a patient-safe future will look like should we take effective action in this area; and state how Patient Safety Learning will play its part in taking action towards the patient-safe future.



shared
learning



leadership



professionalising
patient safety



patient
engagement



data and insight



culture

Shared learning *for patient safety*



The current landscape

Healthcare is systematically poor at learning from harm. This means that different patients are destined to suffer the same kinds of harm over and over. Even when we do find effective solutions to prevent avoidable harm, these are shared slowly, causing patients to continue to suffer harm from problems that others have already addressed.

Learning for patient safety is compromised further because health and social care focuses on responding to unsafe care and the prevention of future harm. While this is welcome, a sole focus on harm means that we miss the important opportunity to design care for safety.

A patient-safe future

If patients are to be safer, we need people and organisations to share learning when they respond to incidents of avoidable harm, and when they develop good practice for making care safer.

In a patient-safe future, we will see patients, clinicians, managers, and health and social care system leaders share learning about safety practice and performance to make care safer.

In a patient-safe future:

- investigations into unsafe care and responding to complaints is important in learning to deliver safer care. Patients are informed and actively participate in investigations. Investigations are undertaken for learning and action; they make a difference to patient safety.
- organisations create a learning culture where they set and make good on goals for learning from patient safety, report on progress and share their insights widely. They prioritise learning to improve patient safety. They respond, and contribute, to shared learning systems.
- regional and local networks support and strengthen geographical and professional communities to share learning.
- organisations encourage, support and remove barriers so front-line clinicians and patients can share learning and learn from others for safer care.

Support from Patient Safety Learning

We have created ***the hub***, a learning and community platform for shared learning. We will provide, on *the hub* and elsewhere, tools, case studies and resources to help organisations improve patient safety.

patient
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learning } *the hub*

Patient Safety Learning will also:

- celebrate learning from patient safety success through the **Patient Safety Learning Awards**.
- comment on investigative practice to understand how health and social care organisations investigate (including systems and human factors thinking), how they learn from harm, and how they can turn recommendations into action and support patients, families and staff.
- support health and social care organisations through support and practical training.



The current landscape

In health and social care, we don't know who is leading patient safety. Or, where we do have leaders, there is no common view of what it means to lead patient safety. Organisations lack a common framework and standards for patient safety within which they all work.

Just as all health and social care organisations must demonstrate that they work to common standards for fire safety, we contend that they all – providers, regulators, commissioners and policymakers – should work also to common standards for patient safety. And, just as fire safety specifies clear roles such as board members and specialists, roles for patient safety should be equally and consistently clear, specified and managed within a clear governance framework.

A patient-safe future

To realise a patient-safe future, we need a model for leadership and governance for patient safety in health and social care that sets and requires high and consistent standards and behaviours of our leaders. This can happen only if we define the competencies and training for those leading for patient safety, and the governance, standards and reporting for the organisations they lead. We seek to see a health and social care system-wide approach to patient safety so all organisations are clear on their collective and individual roles and responsibilities for a patient-safe future.

An effective way to start defining such an approach would be to ensure there is body of leaders to oversee the development, implementation and evaluation of effective approaches, models and governance for patient safety. Its members should include front-line health and social care delivery staff, setters of standards, such as commissioners, system and professional regulators and policymakers. It should also include patient representatives as full members. This forum of leaders for patient safety may be developed from a body that already exists, or it may need to be created afresh. It should emphasise a systems approach and use of human factors, and draw on good practice from across health and social care systems and elsewhere as appropriate.

Support from Patient Safety Learning

Patient Safety Learning will:

- promote discussions and activities to support the establishment of effective leadership for patients, including organisational standards for patient safety.
- promote the establishment of a forum of leaders for patient safety.
- support design, promotion, co-ordination, delivery and evaluation of leadership for safer care.
- explore with health and social care organisations how critical leadership decisions can be more explicitly and routinely risk-assessed for patient safety.
- develop tools such as 'how to' guides, maturity models and self-assessment frameworks to support organisational leadership for patient safety, and publish these on *the hub*.
- offer consulting and training services to help boards and senior leadership teams to improve their governance, systems and capabilities to lead for patient safety.
- provide, on *the hub* and elsewhere, tools, case studies and resources to help organisations improve patient safety leadership.



The current landscape

Many organisations lack a requisite competence framework for patient safety. They lack the means to set and manage consistent standards for patient safety performance. They also lack a consistent basis for defining the skills needed for patient safety, and hence to develop a training curriculum to address these for all staff.

As a result, people in similar jobs may have different skills and work to different patient safety standards. The safety that patients experience may vary considerably from person to person, and from organisation to organisation.

A patient-safe future

We want to see organisational and system standards developed and implemented for patient safety performance, used to inform the delivery and regulation of patient safety.

We want to see the development of an organisational accreditation framework for patient safety.

In a patient-safe future:

- all staff can demonstrate that they are suitably qualified and experienced to carry out their jobs.
- a competency framework, which defines the behaviours, attitudes, skills and knowledge required to deliver safe care, is used in the curriculum for patient safety for all staff.
- training enables a consistent, practical and demonstrable standard of patient safety behaviour.
- organisations have specialist patient safety and human factors experts who are supported by appropriate resources and governance.
- organisations and staff will have access to specialist expertise, support and advice on patient safety issues.

Support from Patient Safety Learning

Patient Safety Learning will:

- identify and develop organisational and system standards for patient safety to be used by commissioners, service providers, regulators, etc.
- promote and support the development of a competency framework for patient safety.
- develop and provide training to address gaps in patient safety skills, knowledge, attitudes and behaviours.
- develop an accreditation framework for patient safety.
- support health and social care organisations and offer practical training.
- provide, on *the hub* and elsewhere, tools, case studies and resources to help organisations professionalise patient safety.

Patient engagement *for patient safety*



The current landscape

Health and social care are still too often designed and delivered around the traditional idea that the patient is a passive participant in the care process. This often results in patients having limited ability to participate in their care because they aren't adequately informed about the stages of their treatment journey and what they should expect to happen.

Patients aren't properly involved in health and social care management and policy. Many patients are unaware of opportunities to get involved in safety at the organisational and policy level. When they do get involved, it is often tokenistic.

A patient-safe future

Engaging patients in their care increases reduces harm. In a patient-safe future, patients are considered part of the team that provides safe care. We envision a patient-safe future where patients are actively engaged throughout the care process and whenever things go wrong.

In a patient-safe future:

- patients and healthcare professionals have the knowledge, skills and attitudes to understand why and how patients should be involved, as well as how to involve patients as active partners in patient safety activities across all levels of the health and social care system.
- patients and families have real-time access to the information needed to allow them to engage in patient safety activities across all levels of the system.
- organisations routinely measure patient engagement in patient safety and evaluate the impact this has.
- regulators, policymakers and commissioners promote and support practical mechanisms for effective patient engagement.
- patients and patient advocates across the health and social care system are supported by a central patient safety organisation.
- patients, families – and staff – are supported and cared for at every stage after an incident of unsafe care.
- investigations fully involve patients and families.
- patients, families and staff are cared for and supported when there is unsafe care.

Support from Patient Safety Learning

Patient Safety Learning will work collaboratively to:

- publish our recommendations on patient engagement in patient safety to identify action needed for improving patient safety.
- develop a model and governance for patient engagement and advocacy for patient safety for service providers, regulators, commissioners and others.
- promote the development of 'harmed patient care pathways' for patients, families/carers and staff, following a death or serious incident of patient harm.
- promote, share, implement and evaluate models for patient engagement in patient safety.
- support health and social care organisations through consultancy and practical training.
- provide, on *the hub* and elsewhere, tools, case studies and resources to help organisations improve patient safety through patient engagement.

Data and insight *for patient safety*



The current landscape

Many efforts have been made to give healthcare organisations useful data on patient safety. Further, organisations have access to a range of patient safety information. But even with access to such data, an organisation's ability to answer the question, 'How do we know we're safe?' remains limited. When it comes to patient safety, it seems organisations are data-rich and information-poor.

Organisations tend to direct their limited resources to tangible goals for which they are obliged to be accountable. We support the setting of patient safety targets for specific issues and conditions but propose that these are accompanied by goals that address the systemic causes of patient safety failure.

A patient-safe future

In a patient-safe future, organisations set effective goals and objectives for systemic causes of patient safety failure in a consistent and compelling way.

In a patient-safe future:

- organisations measure patient safety performance effectively.
- organisations act to improve patient safety performance.
- health and social care systems develop models for measuring, reporting and assessing patient safety performance.
- patient safety performance data is incorporated into risk management systems and monitored by management teams, boards and across the system.
- patient safety performance measurement models are developed into patient safety dashboards at department, board and system levels, and incorporated into formal governance.
- such dashboards include reference or baseline information to act as standards against which patient safety performance can be measured and improvement/impairment tracked.
- there are centralised systems for collecting data on patient safety incidents.
- patient safety is an integral part of AI development.

Support from Patient Safety Learning

Patient Safety Learning will:

- promote the convening of a symposium of experts, expert users and patients to start identifying critical data and insight needed to measure, monitor and determine effective action.
- make recommendations for system-wide data and measurement for patient safety, including organisational dashboards.
- seek to work with technology companies and others to develop, design and implement an effective set of patient safety standards for health apps.
- develop associated tools, such as 'how to' guides, maturity models and self-assessments frameworks, to support organisational leadership.
- work with providers to design programmes for patient safety performance management.
- provide, on *the hub* and elsewhere, tools, case studies and resources to help organisations improve patient safety through data and insight.

Just Culture



The current landscape

An organisational culture that seeks to assign blame when things go wrong makes patient harm more likely to happen again. Evidence shows that addressing safety culture positively impacts on staff behaviours, and that improvement initiatives improve culture.

A culture less centred on blame has a positive impact on patient safety.

A patient-safe future

In a patient-safe future, an organisation's culture encourages and supports patient safety.

In a patient-safe future:

- the environment supports raising, discussing and resolving concerns.
- the organisation is led, and managed, to support patients and clinicians fairly and safely.
- organisations address incidents of unsafe care with empathy, respect and rigour.

We seek to see:

- health and social care organisations implement programmes to eliminate a blame culture and introduce or deepen a Just Culture.
- health and social care organisations develop and publish goals to develop and sustain a Just Culture.
- health and social care organisations measure and report their progress towards a Just Culture.
- staff feel assured that they are working in safe systems. When things go wrong, a system and human factors approach informs investigations and learning.
- patients raise concerns and provide insights into how to make care safer, confident that their views will be welcomed and acted upon.
- organisational goals and programmes are informed by:
 - » organisations reviewing the impact of external factors, as well as their current approaches to patient safety and behaviour, on culture.
 - » regular safety culture assessments of staff and patients.
 - » systems thinking and human factors.
- the design, implementation and evaluation of organisational goals and programmes are shared widely for transparency, accountability and learning.

Support from Patient Safety Learning

Patient Safety Learning will:

- promote Just Culture for improving patient safety.
- provide, on *the hub* and elsewhere, tools, case studies and resources to help organisations and teams learn, adopt and assess Just Culture.
- promote a Just Culture in everything we do and across all our communications and engagement.
- support health and social care organisations through support and practical training.