



A Blueprint for Action: Executive Summary

A Patient-Safe Future

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as a charity with the Charity
Commission Registration number
1180689

Patient Safety Learning
SB 220
China Works
100 Black Prince Road
London SE1 7SJ

e: info@patientsafetylearning.org
www.patientsafetylearning.org

Executive Summary

Patient Safety Learning seeks to transform thinking and action for patient safety

Patient Safety Learning is a charity and independent voice for improving patient safety. We harness the knowledge, enthusiasm and commitment of health and social care organisations, professionals and patients for system-wide change.

We use what we learn to envision safer care. We recommend how to get there. Then we act to help make it happen.

5,526

Patients reported to have suffered serious, life-changing harm in the year to Sep 2018 due to unsafe care²

A Blueprint for Action describes the path to a patient-safe future

Our previous Green Paper, *A Patient Safe Future*³, identified systemic causes of patient safety failure.

A Blueprint for Action builds on this analysis to describe the actions needed to make the patient-safe future a reality.

Patient safety is a major and persistent problem

Every year, avoidable harm leads to the deaths of thousands of patients, each an unnecessary tragedy. Unsafe care also causes the long-term suffering of tens of thousands and costs the health service billions of pounds.

Many people have been doing good work over the last 20 years, but patient safety remains a persistent problem. We propose that health and social care need to think and act differently to make the transformational change needed to realise a patient-safe future.

£2.2bn

direct cost to the NHS of clinical negligence in 2017/18⁴

Patient safety is part of the purpose of health and social care

Patient safety is typically seen as a strategic priority. This sounds important, but it means that, in practice, health and social care decision-makers will weigh (and inevitably trade-off) the importance of patient safety against other priorities, like finances, resources or efficiency.

We believe that patient safety is not just another priority: it is part of the purpose of health care. Patient safety should not be negotiable.

Systemic causes of unsafe care

We believe that patient safety fails for one or more of the following systemic causes:

- Patient safety is not regarded as a core purpose by leaders

- Organisations do not take ‘all reasonable and practical steps’ to improve safety.
- We don't have standards for patient safety in the way that we do for other safety issues, and those that we do have are insufficient and inconsistent.
- We focus too much on responding to, and mitigating the risk of, harm. We don't pay enough attention and take action to design healthcare to be safe for patients and for the staff who work within it.
- We don't learn well enough, share or act on that learning for patient safety.
- Staff working in healthcare are not ‘suitably qualified and experienced’ for patient safety and are not properly supported by leaders and specialists in safety design and human factors.
- Patients are not sufficiently engaged in their safety during care and after harm; patients need to be part of the team.
- We don't have good ways of measuring and performance managing whether we are providing safe care.
- A culture of blame and fear undermines our ambitions to design and deliver safer care.

15%

of hospital expenditure and activity costs are estimated to be due to patient safety failure⁵

Foundations of patient safety

Patient safety is a system-wide challenge. We list below six evidence-based foundations for action to address the causes of unsafe care:

- 1 Shared learning for patient safety
- 2 Leadership for patient safety
- 3 Professionalising patient safety
- 4 Patient engagement for patient safety
- 5 Data and insight for patient safety
- 6 Just Culture

These foundations form the basis of our Blueprint for Action.

Summary of actions

The actions we are proposing build on these foundations and are described in more detail in the full report available at www.patientsafetylearning.org/resources/blueprint.

A summary of these actions is set out below.



7-8

The number of serious harm incidents each year in which the RCGP estimates a typical GP will be involved⁶

Action: shared learning for patient safety

Organisations should set and deliver goals for learning from patient safety, report on progress and share their insights widely.

We are creating *the hub*, an online platform and community for people to share learning about patient safety problems, experiences and solutions.

We research and report on the effectiveness of investigations into unsafe care.

Action: professionalise patient safety

Standards and accreditation for patient safety need to be developed and implemented. These need to be used by regulators to inform their assessment of safe care. We will work with the health and social care system to support the development of these standards.

A competency framework for patient safety is needed to ensure that all staff are 'suitably qualified and experienced'. We propose to work with Health Education England and others to develop this.

Health and social care organisations need specialist patient safety and human factors experts with leadership support, resources and governance. These roles must be clearly defined, with reporting lines to the Board (both Executive and Non-Executive). These specialists will help lead re-design for safety, as well as learning from unsafe care, patient engagement, complaints, near misses, clinical reviews and audits.

Guidance, resources and toolkits need to be developed and implemented with the support of specialist expertise in patient safety and human factors. We will promote and share these through *the hub*.

Action: leadership for patient safety

We call for overarching leadership for patient safety across the health and social care system. We propose a Leadership Forum for Patient Safety will lead the design and co-ordination of safe care and emphasise a systems approach and human factors. This forum should:

- Develop practical models of leadership and governance for patient safety, including how patient safety risk assessments can inform decision-making and the business case for patient safety.
- Map current roles and strategic goals for patient safety.

- Co-ordinate patient safety networks and improvement programmes so that they are systemic in their implementation.
- Share learning.
- Support the development of standards, resources, tools, 'how to' guides, maturity models and self-assessment frameworks.

We recommend that all health and social care organisations publish annually their goals and outcomes for safer care.

We recommend that integrated care systems set standards for patient safety in service commissioning, care delivery and care pathway design.

We will work with the health and social care system to support strengthening leadership for patient safety.

Action: patient engagement for patient safety

We will work with the health and social care system to encourage and support the actions necessary to achieve the following:

- Patients need to be valued and engaged in patient safety at the point of care; if harm occurs; in investigating unsafe care; in the design of service improvements; and holding organisations to account for safer care.
- Organisations need to fund, recruit, train and provide ongoing support for patients engaged in patient safety advocacy.
- Organisations need to ensure that staff and leaders have the necessary knowledge, skills, attitudes and behaviours to meaningfully engage and involve patients in patient safety.

We will initiate development of 'harmed patient care pathways' for patients, families and staff following a serious incident.

We will help develop and support effective patient advocacy and governance for patient safety.

Action: data and insight for patient safety

Models for measuring, reporting and assessing patient safety performance are needed that include quantitative as well as qualitative data. We will convene a panel of experts to identify the critical data and insight needed to measure and monitor patient safety.

We will work to ensure that patient safety is designed into digital health initiatives as a core principle, rather than an add-on.

Hospitals which involved patients reported

38%

fewer harmful medical errors

46%

fewer adverse events⁷

Action: culture for patient safety

All health and social care organisations should develop programmes and publish goals to eliminate blame and fear, introduce or deepen a Just Culture and measure and report their progress.

We will celebrate great work and innovation for patient safety through our Patient Safety Learning Awards and *the hub*.

We can all play a part

Health and social care are complex systems and many organisations and people play a role in patient safety.

We need to better understand how we can all work together to address the systemic issues that cause unsafe care and harm.

It is clear that those below all have key roles in safe care:

- Health and social care leaders and managers
- Patient Safety / Risk Managers
- Frontline clinical and care staff
- System regulators, such as CQC and MHRA
- Professional regulators, such as the GMC, NMC, HCPC and many others
- Department of Health and Social Care
- Policymakers
- The Healthcare Safety Investigation Branch (HSIB)
- Networks representing provider organisations
- Think Tanks, such as the Kings Fund, Health Foundation
- Patients and the public
- Commissioners and funders
- National Patient Safety leaders, such as NHS Improvement
- Academic Health Science Networks
- Patient Safety Collaboratives
- Researchers and academics
- Human Factors experts and safety system designers
- Media

- Politicians
- Royal Colleges
- Arms-length Bodies
- NICE
- Freedom to Speak Up Guardians
- Charities
- Professional societies and associations
- Trade Unions
- Educators
- MPs and Parliament

and many others.

Only by working together can we create a patient-safe future.

Download the complete Blueprint for Action at
<https://www.patientsafetylearning.org/resources/blueprint>

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