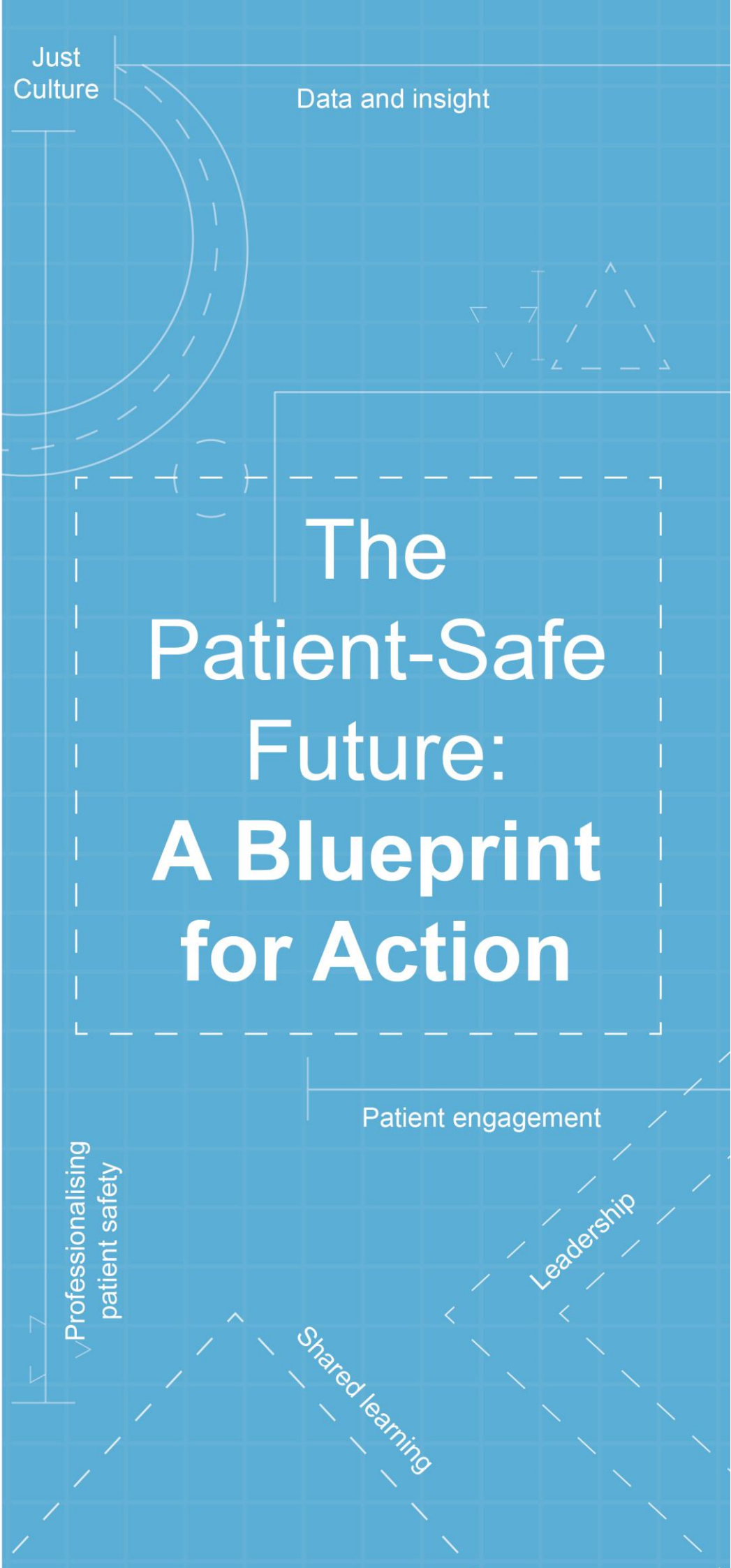
patient safety learning



The Patient-Safe Future: **A Blueprint for Action**

Contents

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Executive Summary

Place the quality of patient care,
especially patient safety,
above all other aims.

Don Berwick, 2013[1]

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.

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.

5,526

Patients reported to have suffered serious, life-changing harm in the year to Sep 2018 due to unsafe care[2]

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 2017/18[4]

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 failure[5]

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. A summary of these actions is set out below.

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:

7-8

The number of serious harm incidents each year in which the RCGP estimates a typical GP will be involved[6]

- 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.

Hospitals which involved patients reported

38%

fewer harmful medical errors

46%

fewer adverse events[7]

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.

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.

1 Introduction

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

Sir Liam Donaldson[8]

A Blueprint for Action

Avoidable unsafe care kills and harms thousands of people each year[2]. To stand by while such suffering continues is intolerable.

A Patient-Safe Future showed that systemic action across inter-related activities is needed if we are to make patients safer. Following its publication, we consulted a range of people and organisations to get feedback on the analysis, vision and proposals it described.

This report, *A Blueprint for Action*, reflects the feedback we received and describes the actions needed to make patients safer. These include actions we call for others to take and actions that we at Patient Safety Learning will initiate.

We propose actions aimed at major causes of unsafe care. If we eliminate or reduce the causes of a problem, we eliminate or reduce the problem itself.

1 in 25

patient safety incidents result in severe harm[9]

Benefits of addressing causes of unsafe care

- If we **share learning** about patient safety, we will equip many more people with tools, insight and thinking that they can use to make patients safer.
- If we create a model of **leadership for patient safety** that is shared system-wide, we can ensure that organisations are led consistently to deliver and improve safer care for patients.
- If we **professionalise patient safety**, we ensure that everyone is informed and skilled in patient safety, including human factors and systems thinking. We can set and reasonably expect consistent standards of safer patient care.
- If we **engage patients in patient safety**, we can make health and social care safer as patients can offer continuity of insight through the stages of their care.
- If we have better **data and insight for patient safety,** we can understand our performance, make better decisions and take more effective action to improve patient safety.
- If we have a **culture for patient safety,** we greatly increase the openness and transparency needed to operate our organisations safely.

Underpinning all of these is the recognition that patient safety is part of the purpose of our care organisations. Only by making patient safety part of every decision – organisational, financial and, of course, clinical – will we achieve a patient-safe future.

The need for action

Efforts over the years attest that patient safety issues are not amenable to easy resolution. In part, this is a result of what has been termed the 'implementation gap,'[11] evidenced by the many cases that lead to well-researched and evidence-based recommendations, but from which little or no practical change obtains.

The case for action is compelling. It is made by each of the thousands of people dying or harmed each year, by the frustrations of staff working in unsafe systems and by the billions of pounds spent as a consequence of unsafe care.

Over the past 20 years, we have come to understand *what* the problems are. Various studies, including *A Patient-Safe Future*, have helped explain *why* patient safety problems exist and persist.

If we are to make the sustained, systemic changes needed to achieve a patient-safe future, we need to understand *how* to make them happen. This is the purpose of *A Blueprint for Action*.

We propose that with systems thinking, human factors and a focus on practical action, it is possible to make patient care safer. We want this report to help everyone who designs, delivers and receives health and social care to make the future safer for patients.

In this report, we describe actions that we think will make a real difference to patient safety. We have taken care to specify actions. We believe these actions are relevant, pragmatic and practical and that they will strengthen and speed up our journey to a patient-safe future.

40%

of NHS acute hospitals' core services,

37%

of NHS mental health trusts' core services, and

22%

of adult social care providers were rated as 'requires improvement' on safety at the end of July 2018[10]"

2 What we learned from *A Patient-Safe Future*

"For me, safety cannot and should not be a distinct silo, but run through everything we do; for only then will it be sustained."

Dr Matthew Inada-Kim[12]

"…patient safety is not just about statistics. Adverse events damage the lives of real people – patients and families – who are affected, harmed or die as a result of that unsafe care. Unsafe care also places a large and needless financial burden both on patients and on the health-care systems that treat them"

World Health Organisation (2013)[13]

Patient safety is a systems issue

A Patient-Safe Future showed that patient safety is a systems issue and that avoidable unsafe care has complex causes.

It identified the systemic causes of patient safety failure. It described a patient-safe future by showing what would be different if these causes were addressed. It also recommended actions to progress towards such a future.

A 90-day consultation started upon publication. Organisations and individuals were engaged directly and online to get their feedback.

A positive reception

Every response welcomed *A Patient-Safe Future* as a valuable contribution to thinking about patient safety.

Respondents said that they appreciated:

- The system-wide view.
- The use of evidence to drive conclusions.
- The concrete way in which the patient-safe future was described.
- The practical nature of the recommendations for action.
- Our proposal to develop and launch a learning platform for patient safety.

There was broad concurrence that action was needed against the five priority areas the Green Paper identified:

- Shared learning
- Professionalising patient safety
- Patient safety data
- Leadership
- Culture

Suggestions for more attention

Respondents suggested areas that they thought had been omitted or which they thought deserved greater emphasis. These included:

- More was needed about how patients can and should be involved for patient safety.
- Greater emphasis on systems thinking and human factors in addressing unsafe care
- The effect of pressure on resources on safe working
- Whistleblowing
- That 'care' encompasses health and social care

How *A Blueprint for Action* reflects what we learned

We reflect the feedback we received in a number of ways:

Patient engagement

We have added a new stream of work: *Patient engagement for patient safety*.

Systems thinking and human factors

The role of system-wide thinking is now more explicit, as is human factors.

Recognising the role of constrained resources and increasing demand in unsafe care

15%

of "…hospital expenditure and activity.." costs are due to patient safety failure[5]

The report recognises the demands on safety of what Liberati et al[14] called 'adverse structural conditions' (such as increased demand and constrained resources). It calls for decision-making about resources and the management of demand that treat patient safety as an explicit priority, minimising compromise in the pursuit of apparent efficiency or cost constraint.

Patient safety failure is itself a substantial cost. It harms patients, diverts clinical resources, increases stress for staff and generates costs that run to billions.

These additional costs can include:

- Additional care and support for patients and families.
- Time and cost associated with complaints and investigations that follow serious safety incidents.
- Time, legal costs and negligence payments to patients or families who litigate.

- Investigations that waste the time of clinicians, managers and patients because they do not lead to meaningful action.
- Duplication of the efforts of others who have already researched and resolved the same safety problems and solutions. Costs in replacing the services of staff suspended during investigation or following whistleblowing.
- Costs in replacing and training new staff where staff involved in incidents of unsafe care feel so traumatised or unsupported that they cannot return to work

Healthcare is not good at assessing and monitoring the full costs of unsafe care, despite the enormous direct costs it represents.

Unsafe care also represents a significant opportunity cost: resources consumed by patient safety failure are resources taken away from caring for others.

When demand on health and social care organisations and staff are growing, such direct and indirect costs are especially important. If resources are constrained, diverting resources from patients must affect the quality and safety of care.

We believe that a powerful business case for patient safety exists: that properly addressing the systemic causes of unsafe care will save costs and free up resources to serve patients better. We think this case needs to be made.

£2.2bn

Direct cost to the NHS of clinical negligence in 2017/18[4]

"The annual cost of…adverse events in England is equivalent to

2,000

GPs

or

3,500

hospital nurses"[5]

Value and protection of whistleblowers in patient safety

Whistleblowers have made a valuable contribution to bring patient safety issues and scandals to light. Many whistleblowers suffer unjust punishment in their professional and personal lives as a result of their decisions to do the right thing by speaking up for patient safety.

Two of our themes ('professionalising patient safety' and 'data and insight for patient safety') include actions to support whistleblowing and greater openness in raising concerns. We recognise, however, that more needs to be done and expect to see more actions to emerge as we engage on 'leadership for patient safety' and 'patient safety culture'.

We need to harness the insight of health and social care staff to improve safety and prevent harm. We should not turn our staff into whistleblowers. We need them to be able to share concerns and know that these will be welcomed, listened to and acted upon.

Patient safety in health and social care

Much work on patient safety focuses on healthcare and predominantly on acute care. More investment in research, policy thinking and design is

needed, however, for the safety of users of primary care, community care, mental health and social care.

We believe that the actions we propose to improve patient safety in health will, in large part, be relevant and valuable in social care. Safety in care needs not just to attend to absolute risks such as safeguarding and infection control but also the complex decisions that enable people to live with dignity and independence. Such thinking becomes especially important given the increasing aspirations to, and focus on, provision of integrated care.

3 Patient Safety is a strategic purpose

"While we have, understandably, focused on specific, targeted initiatives, we have not made wholesale and sustainable progress. We have a long way to go in ensuring that safety is at the core of why every health care organization exists, and what every health care leader believes is their purpose. I describe this as moving safety from a priority to a purpose. A priority is something that we can rate . . . higher or lower. A purpose is timeless and non-negotiable."

Patricia McGaffigan, Institute for Health Improvement, 2018[15]

‘Patient Safety is a priority’ – is this the problem?

Patient safety persists as a problem because, at its heart, it is a systemic issue. We have identified six systemic reasons for patient safety failure, and we examine each of them in this report so that effective action can be taken.

But before we do, we think it worthwhile to consider another, more fundamental, factor to explain why current efforts to address patient safety are so hard to deliver and haven’t achieved the required results.

Health and social care organisations have many strategic priorities: financial priorities, policy priorities, regulatory priorities, patient safety priorities. These are weighed against each other and organisations and individuals decide which ones take precedence. The importance assigned to one in relation to another is a matter of choice.

If patient safety is considered a strategic priority, it, too, becomes a matter of choice. Health and social care organisations choose how much attention, time and resources they devote to patient safety, trading it off against their other priorities.

We know from variations in safety performance assessed by CQC[10] that some organisations pay more attention to patient safety than others. This makes patients who receive treatment in one organisation safer than patients who receive the same treatment in another.

We think it wrong that safety is negotiable. We believe that organisations need to demonstrate that they are taking ‘all reasonable and practical steps’[16] to deliver safe care.

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

The NHS constitution[17] makes several references to patient safety. For example, section 3a, *Patients and the public: your rights and pledges to you*, states:

“You (the patient) have the right to be treated with a professional standard of care, by appropriately qualified and experienced staff, in a properly approved or registered organisation that meets required levels of safety and quality.”

It is striking, however, that this seems to fall short of stating that patients have a right to safe care, with patient safety as part of the *purpose* of care.

"Patients essentially want three things from their hospitals:
don't hurt me,
heal me,
and be nice to me.
And they want them
in that order."
Dr.Bala Chandrasekhar, 2019[18]

The shortfall is subtle, but it makes all the difference in the world. It leads to situations like these:

- How some organisations place responsibility for safety on the shoulders of clinicians and care staff, yet at the same time, they don't ensure that staff work in safe systems, they increase the volume and complexity of the clinicians' and care workers' jobs and then add insult to injury by blaming them when they make mistakes.
- How health and social care organisations measure the harm they do (for example, through the numbers of serious incidents of harm), instead of how safe they are.
- How we don't mine the rich knowledge that comes from reporting 'near misses' and other insights into opportunities for improvement to help us design safer care and to respond better when harm happens.
- How organisations say that patient safety is intrinsic to what they do, then make decisions that affect care (concerning, for example, resources, staffing, facilities or patient service) without explicitly assessing the impact on safety. If organisations don't make these assessments, then they could be making ill-informed and risky decisions without even being aware of it.

Commissioning, contracts and patient safety

Currently Clinical Commissioning Groups are the primary vehicle for the NHS England to spend its health budget.[19] CCGs plan, agree and buy ('commission') healthcare and some social care to meet local needs.

CCGs should therefore be a powerful force to ensure that healthcare is designed and delivered to enable safe care. What mechanisms do they use to commission care and ensure patient safety?

The NHS Standard Contract, published by NHS England, is used by CCGs to commission healthcare services.

The Standard Contract[20] is a template for commissioners to use with providers when negotiating contracts locally. Each contract is developed locally by each CCG and while some conditions are set centrally, CCGs have discretion to negotiate schedules, obligations and conditions within the framework of the Contract. The details of each contract therefore vary from CCG to CCG and provider to provider. Each contract is held at local level and decisions on how a particular contract is managed are made by the relevant commissioner. There is no national oversight on how patient safety is designed into these contracts although each trust has to produce a quality report covering clinical excellence, patient experience and patient safety. As part of this report, trusts are obliged to report on three

indicators of patient safety, with discretion about the ones that they choose to report.

Because the 191 CCGs spend the bulk of the NHS budget,[21] NHS England has a statutory obligation to assess the performance of each one through the CCG Improvement and Assessment Framework (CCG IAF).[22]

This assessment has consequences for each CCG. CCGs deemed to be failing or at risk of failing may be subject to legally binding direction.[23]

For 2018/19, the CCG IAF set 58 metrics against which CCG performance is to be assessed.[24]

Of these 58, only one explicitly refers to patient safety:[24] "*Evidence that sepsis awareness raising amongst healthcare professionals has been prioritised by CCGs.*"

Three more IAF metrics, it may be argued, invoke patient safety under the heading of 'Provision of high-quality care,' on the assumption that 'quality' in this instance includes patient safety.

The complexity of these funding and contractual arrangements and for monitoring and reporting appear to make variations in patient safety inevitable while at the same time making it harder to identify and address the shortfalls that result.

Safety needs to be core to commissioning and the processes and systems that it requires. It is not at all clear how this is the case today.

Planning and patient safety

The currently proposed long-term plan for the NHS is 120 pages long but mentions 'safety' only 23 times. The eight times it mentions 'patient safety' can be found all in section 6, in one paragraph (6.17.ix).[25]

Section 6 of the long-term plan also proposes major initiatives, such as standardisation of procurement; new diagnostic provision; efficiency programmes for community health, ambulance services, primary care and mental health; efficiency savings and automation for dispensing medicines; and standardisation of ambulance fleets. Each offers opportunities and challenges for patient safety.

Of these priorities, only one makes a single reference to patient safety. None emphasise safety or how these initiatives will serve to reduce avoidable harm and save lives.

And while we acknowledge that NHS Improvement has been tasked with developing a National Patient Safety Strategy, we remain struck that the long-term plan makes no reference to the need for a national strategy for

patient safety, or to the need for co-ordinated leadership with a clear map of roles and responsibilities.

If such thinking does not change, then patient safety will continue as it has until now: seen as important, yes, but clearly a secondary tier consideration.

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.

The patient-safe future: patient safety as a purpose

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.

4 Shared learning

"Currently, there are few easy or straightforward ways for people or organisations to reliably share practical knowledge and lessons about safety improvement across a healthcare system.
Knowledge and improvements therefore often remain trapped in the organisations—or individual units—in which they are developed."

Carl Macrae, 2018[26]

Health and social care need to do more to learn for patient safety

In *A Patient-Safe Future*, we made the case that healthcare is systematically poor at learning from harm.

For example:

- Sometimes, when something goes wrong, we don't always analyse the issue effectively, so these investigations draw few meaningful conclusions.
- Or when we analyse an incident, we draw the wrong conclusions so that, for example, we blame people incorrectly when a problem is, in truth, the result of a systems failure.
- Or we analyse an incident correctly but don't act on the recommendations.
- Or we act on recommendations, but don't track how, or if, our actions have worked.
- Or we do investigate correctly and act effectively and track the results, but as we do not share these, no-one else can benefit from our success.
- Or perhaps we try to share our results, but others do not have a good, easy way to find out about them. This is part of what has been called the 'implementation gap' in patient safety[11] and is a feature of Sir Liam Donaldson's 'orange wire' test.[28]

This chain of failure has two effects.

The first effect is that different patients will be destined to suffer the same kinds of harm over and over.

The second effect is that even when we do find effective solutions to prevent avoidable harm, these are shared slowly, in piecemeal fashion, so that patients continue to suffer harm from problems that others have already addressed. This results in a post-code lottery of unsafe care.

Learning for patient safety is compromised further by the ways our current data gathering, analyses and action are almost entirely concerned with addressing patient harm after it happens. We believe that 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, to create the cultural, organisational and system conditions for safer care and to learn from those who have already started to do this.

Only

35%

of recommendations into safety incidents show how to reduce the chance of the incident recurring
CQC 2016[27]

"When a patient safety incident occurs, the important issue is not who is to blame for the incident but how and why did it occur. One of the most important things to ask is what is this telling us about the system in which we work?"
Charles Vincent, 2002[29]

If we are to secure a patient-safe future, we need to find ways of learning how to deliver care safely, as well as avoiding harm. In the jargon, we have to embrace and build on both Safety I and Safety II.[30]

Learning for patient safety is challenging

"There is no clear system for staff to learn from each other at a national level. Local reporting systems are often poor quality and do not support staff well. There are lessons that can be learned from other industries with simpler and more transparent reporting systems, backed up by a culture that drives good reporting."

CQC, *Opening the Door for Change*, 2018[31]

Learning, and the sharing of learning, for patient safety is a persistent problem for a range of reasons (after Carl Macrae[26]).

Improving patient safety isn't prioritised

Many staff might see the opportunity to improve safety but are either too busy to research and develop new solutions or feel disempowered or unsupported to do so.

Sharing learning isn't easy to do

"One of the serious deficits in the NHS of the past has been an inability to recognise that the causes of failures in standards of care in one local NHS organisation may be the way in which risk can be reduced for hundreds of future patients elsewhere."
Building a Safer NHS for patients, 2001[32]

Clinicians, researchers and patients in different organisations lack the facilities and time to come together to discuss incidents and issues and think through possibilities. Collaboration networks exist face-to-face and online, and there are conferences that focus on patient safety. But these are expensive in time and cost, and people find it hard to come together quickly and easily to share experience and learning.

We don't know who else has experience of a safety problem

Staff have few obvious and easy ways to locate and engage peers across the health and social care system with experience of similar problems or who may have worked on similar problems themselves.

We don't know who else has addressed a patient safety problem

Even if staff can carve out some time, they don't have quick and easy access to relevant information about similar problems, possible approaches or tested solutions. They risk duplicating work that others have already done.

Learning to improve safety is hard

Improvements and good practice are not shared

When an improvement happens, it is hard to let people in other organisations know about it. The result is that good practice can remain

isolated in one location while other organisations carry on working in old ways, exposing patients to the same avoidable harm and replicating the same investigations when patients suffer.

Introducing a change in practice is hard

To develop, trial, validate, document, secure approval for, and disseminate, change within the health and social care system takes a lot of time, effort and confidence. Many staff are too busy to take this on or lack the authority to lead such work. The Innovation Accelerator[33] and other initiatives have been set up to address this but the 'implementation gap' remains persistently wide.

We don't have a shared approach to thinking and learning about safety

Different organisations think differently about patient safety

Leaders and managers in different organisations do not have a shared and consistent understanding of patient safety. This can be seen, for example, in the different attitudes and adoption shown across health and social care for ideas such as human factors or Just Culture.

Different organisations learn differently

Mechanisms for organisations to learn from their performance and improve[34] do not operate consistently across health and social care.

We lack an easy, practical way to pass the orange-wire test

Mechanisms for rapid learning and action about safety-critical issues (to address the 'orange wire test') either do not exist, or if they do, such as with 'safety alerts',[35] there is evidence that these can struggle for attention against the avalanche of other information that bombards organisations and clinicians daily.[36]

HSIB

Concerns about a number of these issues were part of the rationale behind the establishment of the Healthcare Safety Investigation Branch (HSIB) in 2017 and some of the investigations and excellent ways of working that have followed.

The majority of investigations, however, continue to be conducted within and by individual healthcare organisations largely beyond the immediate remit of HSIB. As a result, many such investigations continue to reflect the issues described above.

Complaints are an untapped resource for patient safety

'One of the most shocking failures in NHS care was documented on 6th February 2013 when Robert Francis QC published his Public Inquiry into Mid Staffordshire NHS Foundation Trust. He found "a story of appalling and unnecessary suffering of hundreds of people" and added: "They were failed by a system which ignored the warning signs and put corporate self-interest and cost control ahead of patients and their safety."[2]

He wrote: "A health service that does not listen to complaints is unlikely to reflect its patients' needs. One that does will be more likely to detect the early warning signs that something requires correction, to address such issues and to protect others from harmful treatment."[3]

"A complaints system that does not respond flexibly, promptly and effectively to the justifiable concerns of complainants not only allows unacceptable practice to persist, it aggravates the grievance and suffering of the patient and those associated with the complaint and undermines the public's trust in the service.'"

Ann Clwyd and Tricia Hart, A Review of the NHS Complaints System, 2013[37]

"66 per cent found their original report (of the investigation into their complaint) incorrect, inconsistent or substandard. They found levels of investigations below standard or that analysis was inconsistent or weak."

Patients Association, 2015[38]

"Having been involved in hundreds of policy and academic discussions about the quality and safety of health services over the years, I have found that the importance and value of complaints is seldom brought into the conversation."

Sir Liam Donaldson, 2018[39]

208,626

The number of written complaints made to the NHS in the year to March 2018[40]

Complaints made to the health service each year should be a powerful resource for learning about unsafe care. But complaints appear to be a largely untapped patient safety resource.

Complaints provide an opportunity to learn from something that has gone wrong. A shortfall in the quality and safety of care that led to a complaint should therefore act as a vehicle for remedial action, such as a review of processes and procedures followed by changes to the service concerned. When the service failure is of a kind that could, or did, occur in a number of similar settings, the beneficial changes that should flow from complaints need to happen both at the local level where the care was provided and throughout the NHS as appropriate.

Investigations must be better

Concerns about the quality of investigation, however, are not restricted to complaints.

"SI (Serious Incident) investigation in the NHS varies in quality and generally is done poorly."

NHS Improvement, 2017[40]

One of the best sources for learning from patient safety failure is supposed to be the investigation of serious incidents and near misses.

"Rapid, routine and systematic investigation of adverse incidents locally is essential to ensuring that local causal factors are understood and that there is local responsibility for making improvements".

Public Affairs Select Committee, *Investigating Clinical Incidents in the NHS*[41]

If the quality of these investigations is wanting, so will be the learning that follows.

Quality of investigations may fall short for a range of reasons:[42]

- Sometimes those doing the investigation lack investigative skills.
- Sometimes investigations don't properly consider the range of systems and human factors issues involved.
- It may be that investigations are not given the time they need to be thorough, especially if an incident is similar to others that have happened before.
- Or it may be that the organisation treats activities and issues other than investigation as higher priorities.

In sum, the barriers to learning from, about and for patient safety are high and not easily breached.

Only

12%

of incident investigations indicated that they had involved patients and families

Only

35%

of recommendations showed how to reduce the chance of safety incident recurring

Only

39%

of incident investigations included evidence of interviews with staff

Only

28%

of investigations recorded a risk assessment[27]

A patient-safe future: shared learning

"It is rare that organisations and professions try to learn from communities, and yet there is much to be learned from how healthy communities work."

Steve Shorrock[43]

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:

People are enabled to learn

- **Learning is easy**

  When a new strategy, technique, tool, finding, method or process helps make patients safer, other organisations and individuals learn about it easily and quickly.

- **We learn how to improve performance**

  At every level in the health and social care systems, we routinely and systemically learn from their actions and so improve their own performance.

- **We know who we can seek advice from**

  When people working on patient safety want to discuss a problem or seek new ideas, they quickly and easily engage peers across the health and social care system.

Organisations enable learning

- **Comparative performance encourages improvement**

  Organisations compare their patient safety performance with similar organisations across the system.

- **Patients are engaged for learning**

  Organisations initiate, facilitate, encourage and support learning for safety with and by patients.

Improvement is supported

- **Tools and research are easy to find**

  Information about investigations, incidents, strategies, tools or solutions are found quickly and easily.

- **We learn which safety strategies work best**

  People can learn about, assess and compare different patient safety strategies, and know which ones have been proven to be effective.

- **When it works, we share how we did it**

  When a health and social care organisation develops and implements an effective patient safety strategy that makes a

difference, they share the ‘what’ and the ‘how’ with others. We close the ‘implementation gap’.

Investigations are consistently good

- **Investigations into unsafe care and responding to complaints are seen as important in learning to deliver safer care**

  Investigations have clear purposes and objectives that always include engaging with patients, families and staff with empathy, open communication, transparency and respect. When a patient formally complains, their complaint is managed promptly and respectfully.

- **Patients have informed, active participation in investigations**

  Patients have access to patient safety information and processes around patient safety, such as how investigations work and what to expect.

- **Investigations are done well**

  Investigations are efficient, prompt, rigorous and of a consistently high standard. Investigations use a range of analytic approaches, including systems thinking, critical thinking and human factors. They also, where appropriate, use idiographic techniques from the social sciences.

- **Investigations make a difference to patient safety**

  Investigations yield specific conclusions that drive action that delivers explicit improvement in patient safety performance. Investigations are reviewed to validate both their conclusions and how well the resulting actions made patients safer.

Action to enable shared learning

We seek to see:

- 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.
- Organisations prioritise learning to improve patient safety and how they learn from:
  - Incident investigations and complaints
  - Patients and their experiences
  - Good practice within their organisations and others

    - Evaluating their actions to improve safety
    - Sharing their learning with others
- Organisations respond, and contribute, to shared learning systems such as the Patient Safety Incident Management System (PSIMS) - NHS Improvement's replacement for the National Reporting and Learning System (NRLS)[44] – and, we hope, *the hub* from Patient Safety Learning.
- Regional and local networks such as the Academic Health Science Networks (AHSNs) and Patient Safety Collaboratives (PSCs)[45] support and strengthen geographical and professional communities to share learning and build on the 'Sign Up to Safety' networks.[46]
- Organisations encourage, support and remove barriers so frontline clinicians and patients can share learning and learn from others for safer care.

Patient Safety Learning will take action for shared learning

We will:

- Publish a detailed report on shared learning to help organisations take more effective action for improving patient safety.
- Celebrate learning from patient safety success through the Patient Safety Learning Awards.
- Review current investigative practice to understand how health and social care organisations investigate (including systems and human factors thinking), how they learn from harm, turn recommendations into action and support patients, families and staff. We will publish this review and recommend action.
- Support health and social care organisations through support and practical training.

We will create *the hub*: a digital learning and community platform for shared learning

the hub will be the engine of Patient Safety Learning.

the hub will be a platform for the sharing of local, national and, in time, international knowledge, skills, learning and experiences.

the hub will enable people to learn, share and develop key ideas and techniques to improve patient safety, including:

- Accounts and narratives

- Alerts and recommendations
- Case Studies and exemplars
- Data and analyses
- Guides and guidelines
- Incidents and investigations
- Interviews and reflections
- Policies and procedures
- Processes and systems
- Reports and articles
- Safety improvement strategies and interventions
- Seminars and presentations
- Standards and regulations
- Toolkits and collections
- Tools and templates

the hub will foster communities of interest, and practice and give people a safe place to discuss issues that may be of interest or concern to them.

It will provide a collaborative environment for people to come together to build on improvements that have already begun and adapt solutions for local implementation.

Users of *the hub* can discuss learning from investigations and the effect of applying recommendations and/ or solutions to learn how to apply the same solutions effectively.

We want to maximise the reach of *the hub* and encourage as many people as possible to become involved in it, so it will be free of charge for use by everyone: clinicians, patients, managers, policy makers, regulators, researchers and members of the public.

We will nurture and grow *the hub*

We want users to find *the hub* useful, valuable and stimulating. To help, we will:

- Provide editorial support to source, curate, commission and develop content.
- Explore rapid patient safety information sharing.

- Support users in their conversations and ensure that for critical elements, such as descriptions of tools for patient safety, certain quality standards apply.
- Promote, encourage, and support the use of *the hub* to as many relevant communities as possible.
- Support and encourage communities of interest to share knowledge and support each other.
- Help communities connect within and beyond *the hub*.
- Explore ways for organisations to use and support *the hub*.
- Connect the hub to other sites to give our users the widest possible access to learning for patient safety

5 Leadership for patient safety

"The standard you walk past is the standard you accept."

Gen David Hurley, 2013[47]

"There is a strong link between the safety of services and the quality of leadership."

CQC, 2018[10]

Patient Safety needs purposeful leadership

Good leadership is seen as the most influential positive factor in shaping organisational culture in health care,[48] but *poor* leadership can have the opposite effect.[49]

While there are "…any number of ways trustees [Board Members] can improve their oversight of safety,"[50, 51] we are unaware of any agreed, up-to-date, practical guidance as to which way is best under which circumstances.

Frontline clinical staff and patients often work, and are treated, in environments poorly designed for safety that are staffed by increasingly overworked personnel. A key role of leadership is to recognise and address these challenges.

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.

Who owns patient safety?

The publication of *To Err is Human*[52] and of *An Organisation with a Memory*[53] put patient safety firmly onto the agenda of healthcare. One reason we are now publishing *A Blueprint for Action* is that, in the 20 years since, some progress may have been made, but not enough.

When we look at the reasons why, it is easy to blame an absence of leadership. But like the other foundations of patient safety we describe here, leadership for safety is a systemic issue.

On this topic, we can but echo the Care Quality Commission:

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."

CQC, *Opening the Door to Change*, 2018[31]

In other words, it seems that in health and social care, we don't know who is leading patient safety – worse, even if we did, we have not defined what we need them to lead.

In part, this flows from our earlier observation that, currently, patient safety is not regarded as part of the purpose of health and social care. Regardless, however, we have not given our leaders a common view of what it means to lead patient safety.

A framework and common standards

It is salutary to contrast patient safety with, say, fire safety. For fire safety in healthcare organisations, we have established common purposes, aims, policies and guidance on implementation, competences, management, reporting, audit and regulation.[54] We have exemplar fire safety management systems with specified requirements for fire safety management roles, competences, responsibilities, fire safety policies and protocols, and we have standards.

We do not have such an approach for patient safety. Nor is it clear to us whose responsibility it is to create it or require it.

As a result, while the mission statements of many health and social care organisations aspire to the safe care of patients, each organisation does so in their own way. 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, in contrast to the situation that obtains currently.

In fire safety, risk assessment tools are developed, shared and used consistently across organisations. This is not the case in patient safety.

A common framework for leading patient safety and shared standards for governance and management of patient safety must be developed. It will need to be led and managed by a body that can reflect and meaningfully engage providers, regulators and commissioning bodies.

Without a map

Of course, if we are to implement a common framework for leading patient safety and put it into practice, we need first to understand the fragmented, disconnected patient safety landscape within which we currently work. What are the roles and responsibilities for patient safety of the different organisations who define, commission, design, deliver and manage patient safety? Where is patient safety well-defined and led? Where are the inconsistencies? Where do goals, objectives, standards

and governance work at cross-purposes, or are duplicative? Where are the gaps?

At the moment, no-one has mapped this, so we just don't know.

A patient-safe future: leadership for safety

What does leadership for patient safety look like? We propose the following:

- Leaders know the risks to safety in their organisations and attend to them. They require and support the design of safe care, not just addressing harm when it occurs. They do so through formal mechanisms of performance management, of governance frameworks, of understanding culture and patient safety, and reading and responding to reports.
- They 'walk the talk' to engage and listen to clinicians and understand the community and patients. They actively seek insight on whether staff and patients feel safe and, if not, they make sure the organisation knows this and responds.
- Leaders model behaviour that challenges a blame and fear culture. Instead. they strive to ensure a Just Culture and encourage and prioritise learning, treating peers, staff and patients with civility and kindness.[55]
- Leaders make the goals and standards for acceptable patient safety explicit for their organisations, and then resource and support their staff to deliver these.
- Culture, work and workload are discussed explicitly.[56]
- Governance and leadership frameworks for patient safety that specify standards, action and behaviour are in place.
- Leaders measure and report on their organisation's patient safety performance.
- The explicit primacy of patient safety for leaders is reflected in the time, resources and attention they give to it.
- Leaders assess and understand the effect of their decisions and behaviour on patient safety outcomes.
- Leader recruitment, development and performance management is underpinned by a competency framework that specifies the knowledge, skills, attitudes and behaviours needed to lead for patient safety.

- Leaders explicitly attend to, and seek improvement in, the foundations of patient safety, namely:
    - Shared learning for patient safety
    - Leadership for patient safety
    - Professionalising patient safety including standards for safer care and competencies for all staff
    - Patient engagement for patient safety
    - Data and insight for patient safety
    - A Just Culture that supports patient safety
- Leaders are supported by a consistent framework for all of the above, based on shared research and good practices, and underpinned by standards for effective leadership of patient safety, shared across and between health and social care organisations.

Leaders understand that problems in delivering safe care are complex and systemic in nature and, further, that specialist skills in human factors and ergonomics are part of the solution.

We call for action to develop leadership for patient safety

Below, we describe actions that we believe are essential if health and social care is to have consistent, sustained and practical leadership in order to progress to a patient-safe future.

We seek to see:

- A health and social care system-wide approach to patient safety so that all organisations are clear on their collective and individual roles and responsibilities for a patient-safe future.
- Publication of a map of health and social care organisations to support the development of this system-wide approach to patient safety. The map will identify roles, responsibilities and strategic goals for patient safety, gaps and areas where further development and clarity is required.
- Organisations prioritise patient safety, embedding clear and published goals in their leadership and governance with programmes to deliver improvements. Culture, work and workload should be explicit.
- Organisations publish patient safety outcomes as strategic and operational goals.

- Organisations have specialist patient safety and human factors experts in executive and non-executive roles on the Board and leadership teams.
- Organisations design and implement system, processes and performance reporting to manage patient safety risks.
- Organisations use risk assessments to inform the development of patient safety goals and improvement activities, including the design and implementation of solutions to prevent harm.
- Integrated care systems explicitly prioritise patient safety in their design, implementation and operation.
- Standards for patient safety are included in service commissioning and care pathway design and culture; work and workload should be explicit.
- Delivery standards for patient safety are included in service commissioning and care pathway design and delivery.
- Leaders demonstrate through their action and behaviours that they are 'fit and proper' people to deliver safe care, working to the standards developed as part of a patient safety competency framework.

We need effective leadership for patient safety

We believe that for health and social care to be transformed to deliver a patient-safe future, we need a mechanism to ensure that all components co-ordinate and collaborate.

We believe that an effective way to start defining such an approach is to create a body of leaders to oversee the development, implementation and evaluation of effective approaches, models and governance for patient safety.

Its members should include frontline 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.

The forum of leaders for patient safety should emphasise a systems approach and use of human factors.

The forum should draw on good practice from across health and social care systems and elsewhere as appropriate.

If none can be found, it will develop pragmatic good practice, such as:

- A common competency framework for leadership of patient safety.
- Standards for leadership for patient safety, including leading a Just Culture, at every level in an organisation.
- Governance mechanisms for patient safety.
- Tools for sharing and extending patient engagement for patient safety and Just Culture for patient safety in organisations.

Patient Safety Learning will initiate discussions and activities to support establishment of the forum of leaders.

Patient Safety Learning will make resources, such as *the hub*, available for the forum to access sources of good practice, to test possible solutions, to consult and to share the tools and good practice that it chooses to publish.

What Patient Safety Learning will do

Patient Safety Learning will work with other bodies, including the proposed forum of leaders, to:

- Publish a report for leaders to use to help take action to define, develop, support and maintain leadership for patient safety. This will include a leadership model and governance arrangements for patient safety.
- Call for, and help to initiate, design and develop an overarching body for patient safety (the forum of leaders for patient safety).
- Support the 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. Explore the value of using decision support tools, such as safety business cases.
- 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.

6 Professionalising patient safety

"Have you set high standards…that make it clear what level of performance you demand?"

Tom Peters[57]

"If you always do what you've always done, you always get what you've always gotten."

Jessie Potter[58]

"All persons involved in any…safety lifecycle activity, including management activities, should have the appropriate training, technical knowledge, experience and qualifications relevant to the specific duties they have to perform."

Health and Safety Executive (2007)[16]

Who owns standards for patient safety?

In the year to September 2018, just under two million patient safety incidents were reported in the NHS using the National Reporting and Learning System (NRLS). Given such volume, we might expect practices and standards for learning from patient safety to be regular and routine.

Instead, everyday practices for patient safety learning appear inconsistent. We observe a systematic and consistent failure to implement the outcomes and learning from investigations into incidents of unsafe care and patient harm.

If we, rightly, expect standards for patient safety, we need to be clear who sets and owns these.

It is not clear where responsibility for patient safety standards rests in the NHS. The NHS Constitution offers patients:

"…the right to be treated with a professional standard of care, by appropriately qualified and experienced staff, in a properly approved or registered organisation that meets required levels of safety…"[17]

It is not clear to us what is meant by 'levels' in this phrase. What are these levels? What are the standards that should be set for patient safety? Who issues the guidelines to ensure that these standards are delivered? Who measures performance against them to ensure that they are good enough? Who ensures that these standards are met, or exceeded?

It is clear to us that no single organisation is responsible for defining, communicating or evaluating the standards of safety for patient care. In a complex health and social care system, this is not a just a regulatory gap, it is a lack of clarity about leadership for patient safety. It reflects confusion and an absence of ownership for setting standards for patient safety. This needs to change.

A lack of a common framework to underpin consistent care

The Care Quality Commission's Regulation 12 places a patient safety obligation on health and social care organisations.[59]

It states that "…the intention of this regulation is to prevent people from receiving unsafe care and treatment and prevent avoidable harm or risk of harm."

It includes the following statements:

"Care and treatment must be provided in a safe way for service users including:

- Assessing the risks to the health and safety of service users of receiving the care or treatment
- Doing all that is reasonably practicable to mitigate any such risks"

Many organisations struggle to demonstrate how they meet these obligations. One reason is that organisations have trouble complying with another requirement of Regulation 12:

"…ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely…"

"This is not just about the education and training of clinicians. To truly have a safe NHS, all who work in it need to share a basic knowledge and understanding of what we mean by patient safety and be educated in some basic, common principles."
CQC, *Opening the Door to Change, 2018*[31]

Despite this explicit obligation, 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 standard of safety that patients experience may vary considerably from person to person, and from organisation to organisation.

Patients expect that they will receive consistently high standards of care. It is reasonable for these to include high standards for the *safety* of their care.

Organisations should adopt patient safety standards, identify sub-optimal performance against these and act when such performance is identified.

We believe that health and social care currently lacks the means to meet these expectations systemically and consistently. We need to professionalise patient safety.

Raising standards: professionalising safe care

A profession has:

- Standards of education and experience that must be met.
- A code of conduct to regulate professional behaviour.
- Mechanisms for disseminating knowledge of good practice.
- (the ability to) advise government and regulatory bodies about matters within their expertise.

(after Nilsson, H. *What is a profession?*[60])

Many industries use professionalisation to raise standards and make change happen in a consistent and replicable manner. It enables an organisation to ensure that, as the Health and Safety Executive stipulates, staff have the knowledge and skills they need to be 'suitably qualified and experienced' to deliver safe care.[16]

Professionalisation of patient safety will help all staff whose roles affect patients to offer safer care more consistently. Such staff include (but are not restricted to) clinicians, support staff, managers, patient safety specialists, non-executive directors, commissioners and others.

Staff need to know the key concepts, methods and practice of patient safety. Many examples of good practice for patient safety exist in individual organisations. While some of these are showcased through bodies such as Health Education England (HEE) and the 15 Patient Safety Collaboratives of Academic and Health Science Networks (AHSNs), good practice is not shared consistently throughout health and social care.

Patient Safety Learning proposes that 6 components are needed to enable patient safety to be professionalised. Each component complements the other. Together, they provide the knowledge and skills that underpin necessary attitudes and behaviours, as well as supporting organisational cultures that enable safer care.

These components are:

- Clear standards for safe care.
- Accreditation processes for safe care
- Leadership and governance for safe care
- An agreed competency framework to be used as the basis for education and training
- Evidence-based training for all staff, with continual professional development

- Specialist patient safety and human factors experts

New standards and accreditation for patient safety

Professionalising patient safety requires action across the health and social care system. We want to see:

- Standards developed and implemented for patient safety performance, including:
  - Shared learning
  - Leadership
  - Professionalising patient safety
  - Patient engagement
  - Data and insight
  - Culture
- Regulators require and use these organisational standards and that these will inform their regulation of patient safety.
- Guidance, resources and toolkits for patient safety shared across the wider health and social care systems. These are used to enable, encourage and support organisations and individuals to achieve higher standards of patient safety.
- In time, development of an accreditation framework for patient safety.

> "The development and availability of standards for patient safety can…either establish minimum levels of performance or can establish consistency or uniformity across multiple individuals and organizations…The process of developing standards can set expectations for the organizations and health professionals affected by the standards."
> *To Err is Human: Building a Safer Health System, 2000*[52]

In a patient-safe future, patient safety is a core competency

In a patient-safe future, all staff can demonstrate that they are suitably qualified and experienced to carry out their jobs.

Our vision of a patient-safe future includes a health and social care system where:

- All staff demonstrate consistent behaviours, attitudes, skills and principles for patient safety.
- All staff are managed to consistent standards of patient safety performance.
- A competency framework that defines the behaviours, attitudes, skills and knowledge required to deliver safe care to be developed and implemented for all staff.

- This competency framework is used to develop a curriculum for patient safety, so all staff working in health and social care have the knowledge they need.
- All staff working in health and social care can demonstrate their skills for safer care use (Kirkpatrick Level 4)[61] using accredited trainers.
- Health and social care organisations have sufficient access to expertise and qualified resources. As a result, they adopt proactive approaches to improving patient safety.
- Human factors and systems thinking inform the safe design, safety management and approaches to investigating unsafe care.
- Organisations use robust, scientific approaches to the design and implementation of patient safety improvement strategies.
- Core competencies for patient safety are used to define curricula and design training and CPD programmes.
- Incident investigation and implementation of improvement strategies are led to consistently high standards by people who have undertaken recognised, accredited training which includes systems and human factors expertise.
- There are sufficient staff to undertake patient safety critical tasks.

Evidence-based training for patient safety

The 2016 report by the Centre for Health Policy (CHP) at Imperial College London, *Evaluation of Education and Training Interventions for Patient Safety,* is the largest recent investigation into the evidence base for the effectiveness of training interventions for patient safety.[62]

The report made a couple of striking findings. Patient safety training should lead to demonstrably better patient safety performance, yet the CHP study found almost no patient safety training which could demonstrate that it made a difference to working practice. (Kirkpatrick Level 4).[62]

We therefore advocate that any training design includes elements that require participants to review instances of how, where and when the new skills will make a difference to their work.

Further, we propose that training design includes follow-up and reinforcement in-work within a short interval after training delivery to support and encourage use of skills.

Such follow-up will offer a further benefit: it will enable the organisation to identify, and hopefully eliminate, practical barriers to using the new skills.

Another finding of the CHP study was that respondents overwhelmingly deemed four kinds of training to be effective for patient safety training:

- Simulation
- Small group discussion / experience sharing / face-to-face
- Practical / interactive training
- Multi-disciplinary teams (MDT)

Far fewer respondents regarded other forms of delivery, such as online training, to be as effective.

The study further found that effective education and training for patient safety is realised through two equally important elements:

- Knowledge and skills for patient safety and the management of clinical risks, relevant to their role
- The ability to demonstrate the attitudes and behaviours needed for a Just Culture

If we are to professionalise patient safety, it is not enough to set standards, and define a competency framework. We need a standard of training that enables and delivers a consistent, practical and demonstrable standard of patient safety behaviour in the workplace.

Specialist patient safety and human factors experts

Professionalising patient safety requires action across the health and social care system, including the development of specialist roles. We want to see:

- Organisations have specialist patient safety and human factors experts who are supported by appropriate resources and governance. With clearly defined roles, these specialists have clear reporting lines to the Board (both Executive and Non-Executive).
- These experts should support the re-design of systems, processes and operations for safer working.
- These specialists support learning to improve safety from investigations into unsafe care and from listening to, and engaging with, patients, complaints, near misses, clinical reviews and audits.
- Local, regional and national networks of these specialists share knowledge and improvement strategies, supported by the frameworks in place to do so such as Patient Safety Collaboratives, Academic Science Networks, NHSI regional teams and others.
- These roles are underpinned by a strong competency framework and associated training programmes. Their role in setting and

modelling the highest standards for safety and human factor performance is supported by learning from specialists such as Healthcare Safety Investigation Branch (HSIB) and other industry experts and academics.

- These roles being part of a career path in patient safety and human factors with clinical and non-clinical staff encouraged to develop their expertise and into specialist roles.
- Organisations and staff will have access to expertise, support and advice on patient safety issues, with an emphasis on:
    - Developing an open and fair culture and training in patient safety
    - Identifying, managing and reporting of patient safety incidents and risks
    - Running effective, rigorous and empathetic investigations
    - Systems thinking and human factors
    - Acting on, and learning from, safety incidents and improvements
    - Encouraging openness and sharing insight on unsafe care including the support and protection to whistleblowers
    - Support and governance for whistleblowing

Patient Safety Learning will take action to professionalise patient safety

We will work collaboratively to:

- Publish a detailed report on professionalising patient safety to help identify action needed to improve patient safety.
- Identify standards for patient safety to be used by regulators, commissioners, service providers, etc.
- Support development of a competency framework for patient safety.
- Develop and provide training to address gaps in patient safety skills, knowledge, attitudes and behaviours.
- Support development of an accreditation framework for patient safety.
- Support health and social care organisations and offer practical training.

7 Patient engagement for patient safety

"Hear the patient.
Empower the voice of the people we are trying to help.
They have more information than just about anyone
else in the system."

Don Berwick[1]

"Often there is a focus on process, rather than identifying what a patient wants and needs in terms of putting the situation right. Little is known about the emotional and psychosocial harm stemming from medical errors and adverse events. Yet emerging data suggest that these secondary impacts may be just as harmful, or even more injurious, than the underlying event."

The Patients Association[63]

"You ignore at your peril the concerns of a mother."

Margaret Murphy, 2018[64]

The ways we address patient harm can compound the pain

Over the past 20 years, a common factor in many patient safety scandals has been a disregard for the voice of the patient. Patients and family members who raise concerns have had their issues ignored or discounted.

This disempowering of patients was cited as a contributory factor in the 2001 Bristol Royal Infirmary Inquiry,[65] the Mid-Staffordshire Report in 2013,[66] the 2015 Morecambe Bay Investigation in 2015,[67] and the 2018 Report of the Independent Panel for Gosport.[68]

Numerous painful stories illustrate how organisations, after incidents of harm, exclude patients and their families from investigations, learning and improvement. This failure to listen frustrates harmed patients and can make their pain worse,[69] provoke unneeded litigation[70] or require further medical intervention.

"…emerging data suggest that these secondary impacts may be just as harmful, or even more injurious, than the underlying event."

ScienceDaily, 2018[71]

"Emotional and other long-term impacts of harmful events can have profound consequences for patients and families."

Bell et al[72]

Nor is such harm restricted to patients and their families. Clinicians can also suffer psychological harm as a result of being involved in patient safety incidents.[73]

This suffering is a consequence of many of the factors we describe elsewhere:

- A failure, or unwillingness, to listen and learn
- A lack of standards for care following an incident

- A failure of the leadership necessary to put the needs of patients above, say, the desire of the organisation to avoid admitting legal liability
- An unwillingness to involve patients and families in helping to understand what went wrong
- No data recorded or analysed concerning secondary harm to the patient as an issue leading to action
- A lack of formal support for patients and families who have suffered incidents of avoidable harm
- A culture that seeks to close ranks, restrict information and manage blame

If we are serious about patient safety, we must find ways to address such causes to minimise the needless, secondary pain that patients, families and clinicians can suffer in the aftermath of an incident of avoidable unsafe care and harm.

We don't systematically engage patients in their care.

"The patient and family are the only people who are present throughout the continuum of care. They are a repository of critical information and, when engaged and empowered, can play a significant role in ensuring a positive health-care experience. For the same reason, engaging parents and families who have experienced harm can provide insights and learning concerning system failures."

WHO, Patient Engagement for Patient Safety, 2013[13]

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. The systemic model of healthcare is predicated on the use of clinical expertise; a patient with a condition is moved like a passenger through the health system until they are seen by a suitably expert person.[74]

This process assumes that the patient has little expertise to offer. In many cases, this assumption is wrong. Patients with a chronic condition, for example, will often be highly informed[75]. When children are patients, their parents or guardians often have substantial information and insight into their condition.[76]

When health and social care does draw on this expertise such as, say, when a patient history is taken, too often the history does not travel with the patient, is mis-recorded or poorly communicated. This has led to many cases where the patient's own reports of their condition, or reports by parents or family members, are discounted.[77]

The assumption that patients are passengers in the care process is often reflected in how their care is managed. Even when armed with their records, patients may have 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.

Responsibility for safe care rests with the care provider. If patients don't know what 'good' or 'safe' looks like, in terms of the care they should

receive, they will be unable to assess the care they are themselves receiving.[78] Patients are more vulnerable to receiving unsafe care if they do not understand the care they should be receiving or if it is not explained to them. In such cases, they are unable to question or challenge the care they have received or should receive.

If patients were able to check their clinical information during the care process, such problems might be reduced. However, patients typically do not have immediate or direct access to their own medical records, test results or diagnostic imaging results. They are less able to validate their own understanding and so cannot act, should they wish to do so, as a second check that correct protocols are being followed.

Patient care information, for example, can often be handed over between clinicians and between organisations without the presence of, or any direct input from, the patient or their family. If mistakes are made or handover information is incomplete, patients can't correct them.

This needs to change. Patients need to be considered part of the team that provides safe care.

Hospitals that involved patients and families in handovers demonstrated

38%

fewer harmful medical errors, and

46%

fewer adverse events[7]

Investigations are not part of patient care

There is a special case where active patient engagement is often ignored, or discounted: the procedures that follow a serious incident of avoidable harm or death of a patient.

There is evidence that when patients are left out from investigations, the quality of investigation is compromised.[79,80] Patients and families can be a primary source of learning for safety.

Investigation and complaints processes, however, have often not been designed around patient interests or patient care. These processes are often seen to be insensitive, unresponsive and adversarial.[37]

This has a number of effects:

- Patients, families and staff may not be supported when things go wrong.
- Despite assurance and guidance from NHS Resolution and others about the need to apologise, staff often seem fearful or reluctant to do so.[81]
- Staff can be traumatised themselves by their involvement in the serious harm or death of a patient.[82,83] Few support services exist for them[84] and we know that some staff never recover and are lost to the profession as a consequence.[83]
- Families and patients can find it hard to access information or support on what options are available to them for finding out what

Only

36%

of investigations gave patients a chance to discuss the report.[27]

happened, to navigate a complex system through its various stages, such as complaints, the medical examiner's report, a coroner's inquest, serious incident investigation, litigation and inquiries.

When a serious incident of patient harm is investigated, patients too often are not invited to contribute to the investigation, are ignored or have their views discounted.

"Very few reports in our sample recorded the impact and outcome of the incident for the patient or set out how this was managed through additional care or support…reports showed a lack of perspective from the patient or their family on the incident".

CQC, *Learning from Serious Incidents in Acute Hospitals*, 2016[27]

"I cannot think of a single case I have reviewed where poor communication is not a factor leading to poor health outcomes and subsequent disputes: poor communications between patients and health professionals "

Finbar O'Callaghan, The Long and Winding Road, 2015[85]

As a result, patient and family participation in the processes following a serious incident can be a distressing, frustrating, disempowering and exhausting experience, with support, care and funding often available only through the charitable sector by organisations such as Action Against Medical Accidents (AvMA).

In too many cases, this experience causes severe distress and psychological harm to patients and families and to the clinical staff who have been involved in the incident.[86]

Far from being processes of care for people who have suffered avoidable harm, in too many cases these investigations inflict further harm to people who should be receiving healing.[87]

This should not be allowed to continue.

Patients aren't regularly considered as part of health and social care governance

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. If their contribution is actively sought, then they are often poorly supported or trained to contribute effectively.

Health and social care organisations' governance typically does not require patient engagement. Health and social care organisations require governance that creates and requires patient engagement to improve the performance of the organisations.[88]

The case for engaging patients in patient safety is strong

The case for engaging patients in patient safety is more powerful than simply evidencing the harm that poor post-incident care can cause. Simply put: patient engagement makes care better.[90]

Robust evidence shows that communication between clinicians and patients has a positive impact on health outcomes.[91,92,93,94,95,96,97,98]

Failure to adequately involve patients in their care also carries a significant financial cost. For example, in 2015 Marie Curie UK used figures from the NHS Litigation Authority to estimate that communication failures between staff, and between patients and staff, cost the NHS £200-300 million a year.[85]

Engaging patients in their care increases patient safety, reduces harm and potentially reduces costs.

As we have seen, however, much is yet to be done to ensure that patient safety can be optimised by the effective and consistent engagement of patients and families.

> "Empowering patients to be an active participant (sic) of their treatment is not only shown to improve health outcomes, but also effectively reducing safety lapses by up to 15%."
> *OECD, Flying Blind, 2018*[89]

A patient-safe future: patient engagement for patient safety

We envision a patient-safe future where patients are actively engaged throughout the care process and whenever things go wrong.

Patients and professionals are equipped and enabled to engage in safe care

- Patients and health and social care professionals enable patients, if they wish, to partner in all activities related to patient safety across the system. Staff welcome and support this in practical ways.
- 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.

Governance supports, encourages and enables patient engagement in patient safety

- The governance and delivery of healthcare services require patient representation in order to support patient-safe health and social care and hold healthcare organisations to account for patient safety.
- Organisations routinely measure patient engagement in patient safety and evaluate the impact this has. Results are shared within the organisation and between organisations for learning and improvement.
- 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. They will be mentored and supported through an infrastructure that provides support and co-ordination. This will enable patient advocates to develop a collective voice, sharing wisdom, insight and learning.

Patients, families (and staff) are supported and cared for at every stage after an incident of unsafe care

- Investigations fully involve patients and families.
- When patients or families experience harm because of patient safety problems, health and social care systems respond to provide an apology, support, mediation and involvement in investigations, with an open and honest explanation for what happened and why.
- Patients and families feel engaged and supported whenever there is a patient safety incident. Access to appropriate support is enabled, funded and encouraged, including when such support is best provided by third parties.
- Investigations openly and transparently provide explanations and restorative justice.
- Patients and families only need to use the complaints system or instigate litigation if these systems fail.
- Mediation is more frequently used to support families and staff to find a way through the complexity of investigation and complaints processes and to come to quicker and fairer resolutions.
- Patients, families and staff are cared for and supported when there is unsafe care.

> Sincere apologies offered in the wake of a medical error may lead to a lessening of suffering for both patients and physicians in coping with the error and its consequences, contribute to improved relationships between physicians and patients such that these relationships are able to continue, and reduce costs by preventing lawsuits and facilitate the settlement of valid claims.
>
> *J. K. Robbennolt, Apologies and Medical Error, 2009*[99]

We call for action to engage patients in patient safety

If we are to have patients fully engaged in patient safety, organisations in the health and social care system need to act.

We seek to see:

- Health and social care systems welcome and recognise the value of patient engagement and involvement in patient safety.
- Organisations support patients to engage with them to help meet standards, goals and objectives for patient safety.
- Organisations inform patients and the public about patient safety performance against published patient safety goals, standards and metrics.
- Patients become an integral part of an organisation's governance and leadership for patient safety.
- Organisations develop governance and operational roles for patient engagement. These include, but are not limited to, patient engagement and involvement:
    - At the point of care
    - If harm occurs
    - In investigating unsafe care
    - In the design of service improvements
    - In the boardroom
    - In holding the organisation to account for delivery of patient safety standards, goals, processes and objectives
- Organisations fund, recruit, train and provide ongoing organisational and personal support for patient representatives and advocates at all levels.
- Organisations support their staff and leaders to have the knowledge, skills, attitudes and behaviours to engage and involve patients in patient safety.
- Organisations provide consistent support to patients, families and staff when there is unsafe care:
    - Physical, mental health and social care support when it's needed
    - Information and honest explanations about what happened and why
    - Genuine and empathetic apologies

"Patient safety systems are also more likely to be effective if patients are actively involved. Patients need to be encouraged to play a greater part in their care to make sure that they remain safe when treated by the NHS"
CQC, Opening the Door to Change, 2018[31]

    - Advice and guidance about what to expect and the options available for support and redress

What Patient Safety Learning will do

Patient Safety Learning will take action to help patients to engage for patient safety. We will work collaboratively to:

- Publish a detailed report 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.
- Initiate the development of three ‘harmed patient care pathways’ to follow a death or serious incident of patient harm for:
    - Patients
    - Families / carers
    - Staff
- Promote, share, implement and evaluate models for patient engagement in patient safety.
- Support health and social care organisations through consultancy and practical training.

8 Data and insight for patient safety

"Health statistics represent people with the tears wiped off."

Sir Austin Bradford Hill[100]

Do we have the right data?

In practice, patient safety asks a single question of any organisation:

"How do we know that we're safe?"

Professor Alison Leary[101]

Right now, can any leader in health or social care properly answer this question?

It is not for want of trying. Many efforts have been made to give healthcare organisations useful data on patient safety. These include:

- The National Reporting and Learning System (NRLS) is a central database of patient safety incident reports in England. Plans are on the way to replace this system with the Patient Safety Incident Management System (PSIMS).[44]
- The Clinical Practice Research Datalink (CPRD) provides anonymised patient safety records for public health research and analysis, offering reports back to primary care providers. It includes data from 6.7% of the UK population.[102]
- NHS Safety Thermometers employ point-of-care surveys that allow clinical teams to collect, analyse and act on data relating a range of specific conditions.[103]
- The Suspicion of Sepsis (SOS) Insight Dashboard gives clinicians and managers insights to admissions, survival rates and lengths of stay, enabling organisations to benchmark, prioritise improvement strategies and monitor improvements over time.[104]
- Getting it Right First Time (GIRFT) is a national data-driven programme to improve the quality of care by reducing unwarranted variation and sharing best practice. It is being rolled out in 35 surgical and medical specialties and is supported by seven regional hubs.[105]
- The Summary Hospital-Level Mortality Indicator (SHMI) is a NHS Digital programme that models the mortality outcomes of patient hospital care. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.[106]
- The Leapfrog Hospital Safety Grade is a US programme that grades hospitals according to their responses to questions concerning their procedures and practices for aspects of patient safety.[107]

Over and above these specific initiatives, individual organisations have access to a range of patient safety information. Organisations may, for example:

- Have information about the duration of investigations and outcomes after serious incidents or near misses.
- Have information collated on complaints, not just the volume, severity of concerns and response rate, but the insight from these, and the learning that can and has been taken to improve patient safety.
- See reports about the number of clinical negligence claims outstanding, the number settled and the amounts of money to be paid.
- Choose to access the narrative text of incident investigations as well as quantitative data.
- Have information about the progress of specific initiatives towards certain patient safety targets, such as infection control.
- Have potential access to significant qualitative and anecdotal information about incidents, rumours and observations.
- Have access to information about whistleblowing.

The quantity, quality and relevance of such data varies by organisation, as does the quality of analysis, review and action planning that results.

Data-rich, information-poor

Even with access to such data, an organisation's ability to answer the question, "*How do we know we're safe?"* remains limited. There are a number of reasons why:

- Almost all patient safety data refers to patient harm or performance *after* harm has already happened. They provide what is commonly termed 'lagging' information.[108] Such data supports a patient safety stance where the focus is to address harm that has already been suffered.[109]
- Many organisations do not state specific systemic patient safety objectives against which they can be measured. As a result, we consider that their measurement of patient safety can lack direction.[109]
- Only a few patient safety metrics (for example, the SHMI) offer reference information to put an organisation's performance in context. In many cases, this is when organisations have no reference information against which to compare their performance and tell them if patient safety is improving or not.[109]

- We consider that many patient safety scandals (such as Gosport or Mid-Staffs) might have been identified sooner if organisations had more effective ways of viewing and addressing the totality of patient safety performance information available.

  These include, for example, qualitative data such as the numerous reports, queries and flags raised by concerned staff, patients and families but which did not lead to meaningful action early in the events that led to these scandals.[110]

The proliferation of mobile and app technology for health and medical care might seem to offer a way to harness data for patient safety. But as few design standards for patient safety for apps exist, the challenge of finding trusted, relevant sources for patient safety data from billions of downloads is yet unmet.

When it comes to patient safety, it seems, organisations are data-rich and information-poor.

3.7bn

The number of health app downloads in 2017[111]

Setting goals for patient safety

"While we have, understandably, focused on specific, targeted initiatives, we have not made wholesale and sustainable progress."

Patricia McGaffigan, 2019[15]

Goals for patient safety are often set to reduce harm related to a specific condition or practice. Targets are set for infection control,[112] or pressure sores, or falls; actions are taken and after a time, harm levels for these conditions reduce.

Such initiatives have led to some tremendous improvements and many, many patients are alive and well today because of the great work of the innumerable, dedicated staff who made these improvements happen.

Yet, as Patricia McGaffigan asserts above, such initiatives have not led to patient safety nirvana. Despite such attention focused on specific improvements, overall numbers of patients suffering harm stay stubbornly high.[2]

Why?

When under pressure from reduced resources and increased demand, organisations tend to direct their limited resources to tangible goals for which they are obliged to be accountable.[113]

So, while we may see an improvement in specific output targets, this can be at the expense of other patient safety activity, such as addressing the systemic causes of patient safety failure.

Hard numbers drive out soft.

Of course, harm reduction must be embraced. But striving to reduce harm is not the same as striving to be safe. In the jargon, it is the difference between Safety I and Safety II.[30]

If we are to be sustainably safe, we think that initiatives with specific harm reduction targets must be complemented by others that address systemic causes of patient safety failure.

We support the setting of patient safety targets for specific issues and conditions and expect these to have clear and actionable implementation plans. We propose, however, that these are accompanied by goals that address the systemic causes of patient safety failure:

- Shared learning
- Professionalising patient safety
- Leadership of patient safety
- Patient engagement for patient safety
- Data and insight for patient safety
- Patient safety culture.

Currently, few organisations set effective goals and objectives for systemic causes of patient safety failure in a consistent and compelling way.

Three questions for patient safety performance measurement

Before we can answer the question, ‘how do we know we are safe?’, we must first answer three other questions.

1 Against which patient safety objectives are we measuring performance? What should we be measuring?

2 For whichever measures we choose to use, what level of patient safety performance should we have? (What represents good or bad performance?)

   Some may wish to set a target of zero incidents. But even if it is possible, perfect performance is likely to be many years away. Organisations need to set reference data against which they can determine if their performance is good, or not – and if they are improving safety year-on-year.

3 What information tells us if we are becoming more or less safe before harm actually happens? That is, can we have leading, as well as lagging, information about patient safety performance?

Few organisations appear to have good answers to these questions. As a result, most organisations will find it hard to understand, and so act meaningfully, on their patient safety performance.

A patient-safe future: Data and insight for patient safety

In a patient-safe future:

We measure patient safety performance effectively

- Organisations specify clear objectives for patient safety outcomes.
- They set performance standards for these objectives against which they measure performance as part of formal governance and reporting. These standards must be demanding, specific and relevant to patients.
- Organisations use data analytics to identify possible evidence of patient safety risks or potential precursors for such risks.
- They use performance information to identify, track and manage specific risks to patient safety.
- Organisations use performance information to identify, track and manage data for the active design of safety, as well as assessing and addressing the risk of harm, and recording and reporting when harm happens.
- They measure performance routinely against these standards and objectives, using both lagging and leading indicators.

We identify shortfalls in patient safety performance

- When performance is shown to fall short, organisations take specific action to address the shortfall and formally track the results.
- Organisations measure safety performance, and shortfalls in performance particularly, not to blame, but to learn and improve. Regrettably, we believe this will be challenging in the target-focused performance culture of the NHS.
- Organisations set standards for, and measure the quality and effectiveness of, the work they do to improve performance in cases of patient safety failure.

We act to improve patient safety performance

- Every level of an organisation makes better decisions by using reliable patient safety performance information.

- Organisations improve safety by raising patient safety standards regularly.
- Organisations share their safety performance with others.
- They routinely and actively capture, assess, report and act on qualitative information about patient safety from all sources, such as reporting by patients and staff, including whistleblowing.
- They require that apps that claim relevance in health or wellness demonstrate that they have been designed with patient safety as a core principle in their design, development, testing and support.
- Organisations undertake research to identify appropriate and effective metrics and data to monitor and manage safety actively, in addition to risk and harm.

We propose improvements in patient safety measurement

To improve patient safety performance, we seek to see:

- Health and social care systems develop models for measuring, reporting and assessing patient safety performance. These should also include qualitative data on performance and culture, and insights from patients, frontline staff and the wider community.
- Patient safety performance data to be incorporated into risk management systems and monitored by management teams, boards and across the system.
- Patient safety performance measurement models to develop into patient safety dashboards at department, board and system levels, and incorporated into formal governance.
- Such dashboards to include reference or baseline information to act as standards against which patient safety performance can be measured and improvement / impairment tracked.
- Dashboards to include leading and lagging indicators of patient safety.
- Dashboards to include information about reactive and proactive activities to support patient safety improvement.
- Centralised systems for collecting data on patient safety incidents to include insights and learning that follow from investigation and the impact of resulting actions.
- Patient safety to be an integral part of AI development by, for example, engaging with the Department for Business, Energy and Industrial Strategy's Grand Challenge Missions[114] and others to develop capabilities to support patient safety.

These may include, for example, identifying potential precursors to patient safety incidents to enable the development of leading indicators for patient safety.

What Patient Safety Learning will do

We will:

- Publish a detailed report on data and insight to help take action for improving patient safety.
- Convene a symposium of experts, expert users and patients to start identifying critical data and insight needed to measure, monitor and determine effective action for patient safety.
- 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, together with associated regulation and governance.
- Develop associated tools, such as ‘how to’ guides, maturity models and self-assessments frameworks, to support organisational leadership.
- Work with health and social care data providers to design programmes to implement patient safety performance management and measurement.

9 Patient safety culture

(The single greatest impediment to error prevention in the medical industry is…) "…that we punish people for making mistakes."

Professor Lucian Leape, 2009[115]

"You can (and should) identify and blame the error, the 'act or omission' for the harm, but very often it is not appropriate or fair to blame the 'person' who carried out that act. There is a bigger picture when it comes to why that person made that error. This distinction needs to be made clear to everyone, the public and NHS employees."

Jo Hughes, 2016[116]

"Culture eats strategy for breakfast."

Peter Drucker (attr.)

Blame makes patients less safe

As *A Patient-Safe Future* describes, logic, research and innumerable examples all point the same way: an organisational culture that seeks to assign blame when things go wrong makes patient harm more likely to happen again.

A blame culture:

- Incentivises people to cover up mistakes.
- Motivates people to lie, either by commission or omission.
- Encourages scapegoating, especially of people lower in the corporate hierarchy.
- Makes a single person responsible for a failure while downplaying or ignoring the systemic causes behind an incident. As a result, it makes it likely that the same problem will recur with a different person.
- Sets standards for performance that are unachievable with the resources provided.
- Inhibits learning and improvement.
- Is corrosive and undermines trust between colleagues.
- Encourages organisations to exclude or ignore patients or families if things go wrong.
- Makes whistleblowing necessary, as reporting 'bad news' is discouraged.
- Increases the career risk to whistleblowers, as the culture defaults to blaming (and often, shutting down) the messenger.

Evidence shows that improving safety culture impacts on staff safety behaviours, and that improvement initiatives, in turn, improve culture. In short, they form a virtuous circle.[118,119]

A culture less centred on blame, such as a Just Culture[120] has a positive impact on patient safety.

> The medical paradigm demands that the practitioner practises to perfection, and if the person falls short of this high standard, then the person is to blame.
> *S Radhakrishna, 2015*[117]

"For a safe organisation, staff need to be confident that doing the right things – reporting incidents, near misses and concerns, being candid about mistakes and talking openly about error – are all welcomed and encouraged. They need to know that the organisation will focus on system learning, not individual blame.

Of course, there must always be accountability in the rare cases where individual healthcare staff have acted recklessly or have covered up. The term 'Just Culture' describes a culture which successfully achieves this balance."

Patient Safety Learning, *A Patient-Safe Future*, 2018[3]

A patient-safe future: Patient safety culture

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

"Create a culture where clinicians and patients can speak openly in the same room and listen to each other."
Suzette Woodward, 2018[121]

The environment supports raising, discussing and resolving concerns

- The working environment actively promotes and supports the improvement of patient safety. It encourages and enables learning from staff and patients within their organisations and elsewhere in the health and social care system.
- The working environment allows challenge and encourages raising concerns, including whistleblowing, by anyone.
- Health and social care organisations measure organisational culture to identify opportunities to sustain and progress an improved safety culture.
- Successful improvements in patient safety are celebrated appropriately and shared widely.
- Staff and patients feel safe and secure in reporting patient safety concerns, near misses, and incidents, knowing they will be actively welcomed and thanked for sharing their insight, and that action will be taken for safer care.

The organisation is led, and managed, to support patients and clinicians fairly and safely

- A charter of principles and standards sets fair expectations for how health and social care professionals involved in a patient safety incident are supported and treated.
- Health and social care professionals understand their responsibility for patient safety.
- Organisations 'take all reasonable and practicable steps' to improve the safety of patients.

- Work and workload are explicit so that staff are assured that what is expected of them is achievable with the resources available.
- Patient safety risk assessments ensure that resource / safety trade-offs are explicit and understood by decision-makers.

Organisations address incidents of unsafe care with empathy, respect and rigour

- Following a patient safety incident, there is open and honest disclosure to patients and their families.
- Communication and engagement with harmed patients and their family members is prompt, complete, sustained, kind, supportive and empathetic.
- Following a patient safety incident, clinicians and affected staff are given appropriate support. They are confident that the organisation, professional bodies and the wider system will treat them fairly in ways consistent with the principles of a Just Culture.
- Investigations begin with an initial intent to determine the systemic causes of an incident, rather than assuming assignment of liability or blame.
- Patient safety incidents are investigated consistently and rigorously by suitably qualified, accredited and experienced personnel.
- Learning is shared widely for safer care across the health and social care system.

"Civil work environments matter because they reduce errors, reduce stress and foster excellence". *www.CivilitySavesLives.com*[122]

We call for action to develop a culture for patient safety

There have been many reports into how a Just Culture is critical to improve patient safety. Now is the time to learn from these reports and for all, not just the few, to take concerted action.

To make progress towards an effective culture for patient safety, 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 can feel assured that they are working in safe systems and that, when things go wrong, a system and human factors approach will inform investigations and learning.

- Patients can raise concerns and provide insights into how to make care safer, confident that their views will be welcomed and acted upon.
- These organisational goals and programmes are informed by:
    - Organisations reviewing and taking into account how external factors (regulators / policy / commissioning / media) tolerate / support / drive blame cultures in health and social care organisations.
    - Organisations reviewing how their current approaches to patient safety and behaviour tolerates or supports a blame culture.
    - Regular safety culture assessments of staff and patients.
    - Use of systems thinking and human factors.
    - Specialist expertise to inform culture changes and learn from those that are making good progress in this often challenging, but essential, ambition.
    - The design, implementation and evaluation of organisational goals and programmes is shared widely for transparency, accountability and learning.

What Patient Safety Learning will do

To help organisations develop and implement a more effective culture for patient safety, we will:

- Publish a detailed report on Just Culture to help take action 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.

10 About Patient Safety Learning

Our vision is for a patient-safe future
with patient safety as part of the purpose
of health and social care,
not something to be negotiated.
We believe that urgent systemic action is needed
to address the causes of unsafe care.

*"We know why we need to improve patient safety. We better understand what we need to do. We need now to focus on **how** we deliver a patient-safe future."*

Helen Hughes
Chief Executive, Patient Safety Learning

We aim to make patients safer

Patient Safety Learning is a charity.

We help transform safety in health and social care, creating a world where patients are free from harm.

We help health and social care systems and organisations enable safer care for patients.

We identify the critical factors that affect patient safety and analyse the systemic reasons they fail.

We listen to learn about what is needed to make health and social care safer. We use what we learn to envision safer care and recommend how to get there. And we act to help make it happen.

One of our greatest strengths is our independence. We speak truth to power.

Evidence, vision and ambition

We are a small organisation with an ambition that stretches across the whole of health and social care.

The causes of patient-safety failure are system-wide, and we need to use and propose human factors thinking to understand them. We base our thinking and conclusions on firm evidence.

The past 20 years has secured patient safety on the agendas of health and, increasingly, social care. In this time, thousands of recommendations have been made. The need now is for effective systemic action to transform the safety of care.

Our mission matters to everyone, for every single one of us has been, or will be, a patient or care service user. All of us want to be – all of us deserve to be – cared for safely. Improvement in patient safety will come with the hundreds of thousands of people every day who provide care and try to make things better.

And so we collaborate with staff, patients and their families; those who have suffered first-hand and who want their experience, their insight and their learning to make a difference. By partnering with them, we aim to achieve the transformation we all need.

We would like to partner with you too. Contact us to find out how together we can aspire to a patient-safe future.

Learn more about us

Learn more about Patient Safety Learning and our goal of creating a patient-safe future.

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