



Developing a patient safety strategy for the NHS: consultation response

Consultation Response

©2019 Patient Safety Learning
All rights reserved.

Patient Safety Learning is registered
as a charity with the Charity
Commission Registration number
1180689

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

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

Contents

Patient Safety Learning's role and ambition.....	4
Answering your specific questions	8
Q1: Principles.....	9
Q2: Insight.....	16
Q3: Infrastructure	18
Q4: Initiatives	30
Appendix A.....	33

Patient Safety Learning's role and ambition

Patient Safety Learning

We are a new charity that aims to transform safety in health and social care, creating a world where patients are free from harm. We help healthcare systems and organisations enable safer care for patients and identify the critical factors that affect patient safety and analyse the systemic reasons they fail. We use what we learn to envision safer care, make recommendations on how to get there and will act to make it happen.

Our Green Paper

Towards A Patient-Safe Future was written in response to the fact that patient safety persists as a serious threat to patients despite the many initiatives, investigations, enquiries, analyses and recommendations that have been made over the past twenty years.

Different thinking and action are needed.

Our Green Paper, *A patient-safe future* recognised that patient safety is a systems issue and patient safety failure has complex causes.

It identified systemic causes of patient safety failure, described what would be different if these were addressed and articulated what a patient-safe future could look like. Then it recommended actions to progress towards such a future

After it was published, we started a ninety-day consultation. Organisations and individuals were approached to get their thoughts, and people could also respond online.

A very positive reception

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

In particular, respondents 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

Our White Paper

Patient Safety Learning's White Paper, *A Patient-Safe Future: A Plan for Action*, builds on the 'why' and the 'what' of patient safety outlined in the Green paper and develops more of the 'how'.

Evidence shows that safer care requires inter-related activities and we highlight what we believe are key priorities to tackle the persistence of harm.

Our action plan for safer care comprises six inter-related themes

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

For each, we outline actions that we believe are needed to progress: those that need a system-wide response and others that Patient Safety Learning will deliver in the coming years. We include a summary table of these actions as Appendix A.

Patient Safety Learning's summary response to NHSI's consultation

We agree that we need to see a systems wide strategy across all of health care. We are a little disappointed that the recent NHS long-term plan makes so little mention of patient safety. We strongly believe that delivering safer care is integral to the planning, commissioning, delivering and regulating of healthcare. A separate patient safety strategy will be invaluable but only if it contributes to safety having the priority needed to address high levels of avoidable harm for patients and service users.

We note that you state that your remit for patient safety extends to all areas of NHS-funded care in England, wherever people use the NHS and whatever their diagnosis. To ensure that we have a system-wide approach to patient safety in health and social care we believe that we need a strategy that is system-wide.

A key building block will be a map of everyone's responsibility for patient safety to show how the whole system currently operates and to identify gaps or overlaps in how the patient safety system operates. Such a map should include: commissioners and providers of health and social care; system and professional regulators; policy makers; patients and families; politicians; professional associations and trade unions; clinical leaders; charities and social enterprises.

We believe also that system-wide leadership for patient safety is needed to ensure that priorities and programmes are aligned and effectively implemented. We welcome your suggestion that NaPSAC will become a cross-system safety committee akin to those in other sectors. In this role it can support the whole health and care system response to the recommendations from Healthcare Safety Investigation Branch's (HSIB's) investigations. But we think that this focus should be broader than just responding to the insights from investigations.

In our White Paper our recommendations for leadership on patient safety includes a Forum of Leaders. This Forum should draw on good practice from across the health and social care systems. Where none is available, it should develop pragmatic good practice such as

- A common competency framework for leadership of patient safety
- Standards for Board behaviour and performance in relation to patient safety
- Appropriate metrics for Boards to use to measure activities against causal factors for patient safety performance and patient safety outcomes
- Appropriate contextual reference information against which patient safety data can be assessed
- Governance mechanisms for patient safety
- Tools for sharing and extending just culture for patient safety in their organisations

You identify key challenges. We would add that the evidence that investigations into unsafe care are often poorly conducted and we're not learning from these. This results in poor action planning and recommendations not being implemented for improvement.

We also strongly believe that we're not effectively sharing learning about:

- What goes wrong
- What is excellent
- The actions needed to make improvements
- How these improvements can be effectively implemented
- Evidence of strategies and action that have led to safety improvement

- Sharing this knowledge for wider benefit
- Design and development of tools to help us with implementation.

So we strongly believe that there should be a greater focus on need for learning, sharing this learning and closing the implementation gap

Answering your specific questions

Q1: Principles

1A. Do you agree with these aims and principles? Would you suggest any others?

Your three aims

Your proposed strategy has three aims for the NHS.

- be world leading at drawing insight from multiple sources of patient safety information
- give staff at all levels the skills and support they need to help improve patient safety, so they can be the infrastructure for safety improvement, working with patients and partner organisations
- decrease harm in key areas by 50% by 2023/24 and beyond through specific patient safety initiatives.

We believe that insight is essential, but we need to do more. We need to draw and share insight *for learning* (our italics).

Sufficient resources are needed to provide safe care. Trade-offs made between different priorities of performance and patient safety need to be explicit and evidence-based.

Part of effective resourcing is professionalising patient safety, setting standards with a competency framework for patient safety.

Your three principles

You focus on three principles that should underpin implementation of the strategy: a just culture, openness and transparency and continuous improvement.

We welcome your reinstatement of these principles and look forward to seeing detailed proposals for implementation.

You invited suggestions for other principles, and we would ask you to consider the following:

- Shared learning
- Patient engagement in patient safety
- Systems thinking and human factors

1B. What do you think is inhibiting the development of a just safety culture?

Our White Paper provides details of the research evidence and ready availability of tools and techniques of improving safety culture. Sir Ron

Kerr's recent review of NHS Leadership found that there was still a great deal of work to do:

“The NHS must empower leaders to lead, encouraging them to celebrate their successes and learn from their mistakes. In reality, a culture of blame and negativity continues to pervade the NHS. Despite best efforts, it is a fact of life that mistakes are made and error is unavoidable. The NHS needs to get much better at learning from both successes and failures, moving to a more open learning culture”

(DHSC, 2018c, p.6)

We envision what a patient-safe culture might look like in practice

- **Leadership:** Leaders acknowledge that healthcare is a high-risk environment. They align vision/mission, staff competency, and fiscal and human resources, from the boardroom to the front line. Leaders show they understand the science of safety and the power of data. They have insight into safety problems and make patient safety a continuing priority.
- **Teamwork:** Executives, clinicians and their colleagues in patient care share a spirit of collegiality, collaboration, and cooperation. Relationships are open, safe, respectful, and flexible.
- **Evidence-based care:** Patient care practices are based on evidence. Processes are designed to achieve high reliability and standardize to minimise variation.
- **Communication:** Individual staff members, no matter their job description, have the right and the responsibility to speak up on behalf of a patient. Front-line staff see that communications with managers are heard and acknowledged. Providing feedback and closing the loop builds trust and openness.
- **Learning:** The organisation learns from its mistakes and seeks to improve safety performance. Learning is valued by all staff, including medical staff.
- **Just:** The organisation's culture recognises errors as system failures rather than individual failures. At the same time, it does not shrink from holding individuals accountable for their actions. Staff at all levels see raising patient safety concerns and report near misses as a professional duty and this is supported and welcomed, formally and informally.
- **Patient-centred care:** Patient care is centred on the patient and family. Patients are valued as equal partners in their care. When

things go wrong, they are fully involved in investigative processes and have the opportunity to help improve patient safety.

(Adapted from Stavrianopoulos, 201240)

1C. Are you aware of A Just Culture Guide?

We are aware of the *Just Culture Guide*, and its predecessor, the *Incident Decision Tree*.

We believe it to be a very valuable tool. We are unaware of how widely this tool is known and used by patient safety experts, clinical governance managers, risk managers, HR professionals and executive and non-executive leaders in delivery organisations and regulatory bodies.

What has been the impact of using the tool and what are the opportunities for its wider application?

1D. What could be done to help further develop a just culture?

We propose the steps below to develop a Just Culture for patient safety (adapted from our White Paper):

Just Culture Area	Proposed Action	How This Could Be Practically Supported
Commitment to the development of a just culture	Leaders and Board explicitly commit their organisations to develop a just culture with regard to patient safety.	Health and social care organisations to develop and publish goals to develop and sustain a Just Culture Development of materials aimed at Board members outlining the principles of a just culture. Health and social care organisations to develop and publish goals to develop and sustain a Just Culture Health and social care organisations to measure and report their progress towards a Just Culture
Baselining the current position and building from there	Organisations take action to understand what their starting position is with regard to a just culture	Ensure leaders and professional patient safety staff are trained in the concepts of just culture by making good quality training materials easily available. Incorporate optional questions in the national NHS staff survey that relate to health and safety into future surveys

Just Culture Area	Proposed Action	How This Could Be Practically Supported
		<p>Organisational goals, policies and programmes to be informed by:</p> <ul style="list-style-type: none"> • how external factors (regulators / policy / commissioning / media) tolerate / support / drive blame cultures in health and social care organisations • how an organisation's current approaches to patient safety and behaviour tolerates or supports a blame culture • regular safety culture assessments of staff and patients • whether serious incident investigations identified a person or persons to blame as the only or primary source of failure • use of systems thinking and human factors
Taking practical steps to reflect and support Just Culture	Organisations make changes that support Just Culture and reduce focus on blame	Change processes, systems and reporting so that investigations apply systems thinking and human factors as a default, routinely as required.

Just Culture Area	Proposed Action	How This Could Be Practically Supported
		Track the number and proportion of serious incident investigations where the only or primary explanation involves the assignment of blame.
Implementing Policies that Support a Just Culture	Look at current policies and procedures and ask if they support, are neutral or work against the principles of a just culture. Amend or develop new policies as required.	Develop examples of good practice that are easily accessible and adapted for local circumstances.
Supporting Staff	Develop a staff charter that sets out how staff involved in a patient safety incident and/or investigation will be involved and supported throughout the process.	Develop a standard model that can be adapted for local circumstances. Initiate the development of a 'patient harm care pathways' for staff to be used to support them whenever a death or serious incident of patient harm occurs
Supporting Patients and Relatives	Develop a Patient and Families charter that sets out how patients and families involved in a patient safety incident and/or investigation will be involved and	Develop a standard model that can be adapted for local circumstances. Initiate the development of 'patient harm care pathways' for patients, families and carers to

Just Culture Area	Proposed Action	How This Could Be Practically Supported
	supported throughout the process.	be used to support them whenever a death or serious incident of patient harm occurs
Supporting expert patient safety staff	Ensure that expert patient safety staff are fully trained in the concepts and practice of a just culture.	Ensure there is accredited training.

1E. What more should be done to support openness and transparency?

Healthcare organisations should define and publish goals for patient safety performance. Organisations should regularly and routinely publish their performance against these goals, as well as the progress and results of the actions they have taken to address any shortfall in performance.

Organisations should improve patient engagement with patients holding organisations to account for patient safety performance

1F. How can we further support continuous safety improvement?

We should expect all NHS organisations to set standards for patient safety and use reported patient safety performance and risk assessments against these standards to shape and direct improvement efforts.

NHSI and others should work with NHS organisations to develop a practical model to determine the cost of patient safety failure and the savings that will result from patient safety improvement. This will greatly help organisations to scope patient safety initiatives and develop business cases for patient safety initiatives.

Q2: Insight

2A. Do you agree with these proposals? Please give the reasons for your answer.

In principle, we commend all the initiatives outlined in these proposals for “Insight”. We would, however, ask that they are reviewed in the light of the following questions.

The first and most important question to be asked of data for patient safety is this: “Do we know whether we are safe?” We don’t think that we have developed effective ways of answering this question and that more needs to be done in using qualitative and quantitative data to design reporting and performance systems.

The next most important question is “What should we measure to understand our patient safety performance?” This question, of course, can only be answered if we have set our objectives for patient safety. If we have not set these objectives, then we run the risk (see below) of measuring (and hence paying attention to) the wrong things – of having the data tail wag the patient safety dog.

So while we think that the initiatives you describe under “insight” are almost certainly valuable and good, we believe that unless strategic patient safety objectives have been set by and for healthcare organisations, the risk is high (a) that some initiatives will succeed and others will fail simply because they are deemed more relevant than others and (b) some patient safety problems will persist because we are not seeking data about them.

2B. Would you suggest anything different or is there anything you would add?

We are pleased to see you cite Safety II as an aspiration you wish your initiatives to support. We too believe that we must strive as much to make healthcare safe as we do to address avoidable harm: hence Patient Safety Learning’s ambitions and describing a ‘patient-safe future’. In this light, we observe that almost all of the initiatives you describe are concerned with gathering and reporting information about incidents of harm after they have happened; that they are, in the jargon, concerned with ‘lagging’ indicators of patient safety.

The one exception is where you make mention of the possibility of using AI and machine learning to gain insight from the new Patient Safety Incident Management System to enable Safety II thinking. We agree that the potential that this may offer must be explored.

We would, however, ask that more attention be paid to identifying ‘leading,’ not lagging forms of data for patient safety. We know, for example, that there are systemic reasons for unsafe care, where we need to do more to:

- share learning about patient safety incidents, causes and solutions, informed by human factors and systematic thinking
- set organisational strategic goals, governance, leadership, metrics and reporting for patient safety
- meaningfully engage patients in patient safety and to have patients hold organisations to account for patient safety
- set, implement and support professional standards of performance and competence for all staff whose activities influence patient care
- set objectives and standards against reference data for patient safety, and for which they gather data to measure their performance, gather insight, take action and track learning and improvement
- create and operate a culture that encourages safe healthcare, that supports patients, families and staff, that recognises that performance failures arise largely from systemic failure while ensuring that personal responsibilities are clear.

We suggest that organisations that gather, track and respond to data about their performance in these areas will be safer, as they will be managing and addressing the causes of patient safety failure. It would be helpful if your insights programme included initiatives that addressed this.

Q3: Infrastructure

3A. Do you agree with these proposals? Please give the reasons for your answer.

To answer this question, we first need to describe the direction we believe patient safety should take, towards a patient-safe future. We believe that a patient-safe future includes:

- Processes to train all healthcare workers in foundation principles of patient safety.
- A common competency framework that defines the knowledge, skills, attitudes and behaviours and levels needed for everyone whose work affects patient safety. This includes clinicians, care-givers, ancillary staff, managers, chief executives and board members. It should also include professional and national regulators, commissioners and policymakers.
- A syllabus of training to address these competences and levels of performance.
- Standards for training delivery. A range of training providers offer appropriate, high quality training/qualifications. These providers are professionally accredited so that patient safety training meets these standards.
- Standards for patient safety performance
- Systems in healthcare organisations to ensure that only suitably qualified and experienced persons perform activities which are crucial to patient safety.

Professionalised approach to patient safety

We are proposing a professionalised approach to patient safety including

- All staff to be suitably qualified and experienced in patient safety:
- All staff working in health and social care are trained in the foundation principles of patient safety
- A competency framework is developed and implemented that defines the behaviours, attitudes, skills and knowledge required for all staff to deliver safe care
- A curriculum for patient safety is developed and used in the training of all staff working in health and social care

- Standards to be developed and implemented for patient safety performance in:
 - Shared learning
 - Leadership
 - Professionalising patient safety
 - Patient engagement
 - Data and insight
 - Culture
- Regulators to require and use such organisational standards to inform their assessment of patient safety
- Guidance, resources and toolkits for patient safety to be developed and shared across the wider health and social care systems. These are to be used enable, encourage and support organisations and individuals to achieve higher standards of patient safety.
- In time, to develop an accreditation framework for patient safety
- Organisations to have specialist patient safety experts to inform, support and accelerate the development and implementation of patient safety strategies and objectives.
- Organisations to underpin these roles with a career path that encourages clinical and non-clinical staff to develop their expertise in patient safety and quality improvement
- Organisations and staff to 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
 - identification, management, investigation and reporting of patient safety incidents and risks
 - systems thinking and human factors
 - encouraging openness and sharing insight on unsafe care including the support and protection to whistle-blowers

- Organisations use robust, scientific approaches to design and implement patient safety improvement strategies.
- Incident investigation and implementation of improvement strategies are led by professionals who have undertaken recognised, accredited training which includes systems and human factors expertise.
- Patients and families feel engaged and supported whenever there is a patient safety incident. Investigations fully involve them and openly and transparently provide explanations and restorative justice.
- When patients or families who experience harm because of patient safety problems, healthcare systems respond with empathy to provide an apology, support, involvement in investigations and an open and honest explanation for what happened and why. Patients and families should only have to turn to the complaints system if these systems fail.

Competency framework

This competency framework needs to be developed for all those that contribute to health and social care and the safety of patients and carers including:

- Patients and carers (as receivers of health and social care and advocates)
- Support staff (both directly and indirectly employed)
- Clinical staff
- Leaders and managers
- Specialist Patient Safety Staff (Clinical Governance Leads, Patient Safety Managers, Investigators for example)
- Board members and executives
- Professional Regulators
- System Regulators
- Policy Makers
- Politicians

3B. Would you suggest anything different or would you add anything?

You propose patient advocates for safety to ensure patients are heard throughout the system. We think there is a strong case for improving patient engagement on the evidence that harm can happen, can be made more likely or the effects made worse if patients are not involved.

We think that your proposal should be more ambitious. There is a clear requirement for a system-wide, comprehensive, patient engagement for patient safety programme.

Many investigations into serious incidents, for example, side-line patients, causing further harm to patients and families. Indeed, many of the most serious patient safety scandals continued and grew because healthcare organisations ignored and discounted patients during the investigation process.

Regardless of the damage done by cutting patients out of investigations, clear evidence exists that investigations – indeed patient treatment itself – have better outcomes if patients are active participants. Please see response to question F below

3C. Which areas do you think a national patient safety curriculum should cover?

See answer 3A regarding professionalising patient safety.

We also believe that we need a competency framework for patient safety that defines the knowledge, skills, attitudes and behaviours and levels needed for everyone whose work affects patient safety. This includes clinicians, care-givers, ancillary staff, managers, chief executives and board members. It should also include professional and national regulators, commissioners and policymakers.

3D. How should training be delivered?

We commend the recommendations in the 2016 Report, *Improving Safety Through Education and Training*, by the Commission on Education and Training for Patient Safety for Health Education England; these should be used as design criteria for patient safety training.

In our opinion, however, doing so should be enhanced, however, by some of the findings in the academic research upon which the report was built – the report by the Centre for Health Policy at Imperial College London: *Evaluation of Education and Training Interventions for Patient Safety* (2016).

The report made a couple of striking and relevant findings. First, that almost no patient safety training could demonstrate that it made a difference to working practice. (Kirkpatrick Level 4).

It is essential that any patient safety training results in better patient safety performance. 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, and that training design includes follow-up and reinforcement in-work within a short period of initial training delivery to support and encourage use of skills and to identify practical barriers to use of what has been learned.

The other striking finding was that only four kinds of training were overwhelmingly deemed as effective for patient safety training:

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

Far fewer sources deemed other forms of delivery, such as online training, as effective for patient safety.

We would therefore suggest that any training intervention incorporates uses one or more of these top four methods if it is to be effective.

3E. What skills and knowledge should patient safety specialists have?

We refer you to our answers to 3C in general.

A core set of advanced patient safety knowledge, skills and behaviours would be helpful, these should be developed as part of a competence framework and might include:

- Patient safety science
- Human factors & ergonomics
- Safety investigation
- Patient / family / carer engagement
- System thinking
- Risk management
- QI science

- Prospective risk / hazard analysis and other safety tools and techniques
- Delivering education & training
- Data analysis
- Incident reporting & management
- Change management
- Communication skills
- NHS patient safety systems
- Components of a patient safety culture
- Patient engagement for patient safety
- Complaints management
- Governance and leadership for patient safety
- Evaluation
- Appreciative enquiry
- Team work and collaboration
- Health and safety legislation

3F. How can patient/family/carer involvement in patient safety be increased and improved?

Evidence demonstrates that patient / carer involvement in patient is essential if patient safety efforts are to succeed.

A common factor in many – perhaps most – of the patient scandals in the past twenty years has been a disregard for the voice of the patient. Patients who raised concerns had their issues ignored or discounted. Such disempowering of patients has been cited as a contributory factor in the 2001 Bristol Royal Infirmary Inquiry, the Mid-Staffordshire Report in 2013, the 2015 Morecambe Bay Investigation in 2015 and the 2018 Gosport Inquiry.

A wide range of research shows how patient harm can be exacerbated because patients or their families are excluded from events that follow from an incident.

A strong case for improving patient engagement for patient safety can be made just on the evidence that if patients are not involved, harm can happen, can be made more likely or the effects made worse

That we have to make the case for doing so shows, however, that it does not happen as a matter of routine.

Why patients are not engaged

We suggest that patients are not engaged in patient safety for a number of reasons.

- Our model of healthcare is still too often designed and delivered around the traditional idea that the patient is a passive participant in the healthcare process.
- The systemic model of healthcare is predicated on the use of clinical expertise. A patient with a condition is moved through the health system until they are seen by a suitably expert person. (The design of the healthcare system assumes that the patient has no expertise to offer. In many cases, this assumption is wrong. Patients with a chronic condition, for example, will often be highly informed. When children are patients, their parents or guardians often have substantial information and insight into their condition.
- While healthcare does draw on this expertise to take a patient history, too often the history does not travel with the patient, is misrecorded or poorly communicated. This has led to many cases where the patient's own reports, or the reports of parents or family members, are discounted or ignored.
- Patients may not have timely direct access to their own medical records, test results or diagnostic imaging results. Therefore they are less able to validate their own understanding and act as a second check that the correct protocols are being followed.
- Patients often don't know what 'good' looks like, in terms of the care they should receive, to help them assess the care they are themselves receiving. This has led, on occasion, to patients receiving unsafe care because they did not know the standard of care that they should receive.
- Patient care information can often be handed over between clinicians and between organisations without the presence of, or any direct input from, the patient or their family.

- Once they become an inpatient, patients who are concerned about their care or condition can be denied the ability easily to escalate care themselves if they are unhappy or concerned.
- When a serious incident of patient harm is investigated, patients too often are ignored or discounted by the process for review and investigation and the process leaves them further traumatised and damaged.
- Further, it has been shown that when patients are left out from investigations the quality of investigations can be compromised
- When a serious event happens, we don't have standard ways of informing, managing and supporting patients, families or staff so that issues are addressed, information is gathered effectively, and secondary harm is minimised.
- Many patients are not aware 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 trained or supported to contribute effectively.
- Organisations do not have governance, metrics or mechanisms to seek patient insight or to enable patients to hold them to account for patient safety performance

All the evidence suggests that patient care and patient safety improve if patients are actively involved in their care. The issues above, however, need action if this is to happen effectively.

A patient-safe future where patients are actively engaged

We envisage in our White Paper that in a patient-safe future, patients are actively engaged throughout the care process and whenever things go wrong.

- Patients and healthcare professionals expect that patients, if they wish, will partner in all activities related to patient safety across the system, and staff welcome and support this in practical ways.
- Patients are represented in the governance and delivery of healthcare services so that they support patient-safe healthcare and hold healthcare organisations to account for patient safety

- A central organisation support patients and patient advocates across all their organisations in the health care system. This central organisation helps to capture and share best practice, support regulatory activity, develop expertise and offer access to patient insight across the healthcare system
- Patients and healthcare professionals have the knowledge and skills to understand why patients should be involved, and how to involve patients as active partners in patient safety activities across all levels of the healthcare system.
- Patients and healthcare professionals are given necessary education and training to carry out their roles in patient engagement in patient safety across all levels of the system
- Patients have full and timely access to all the relevant information needed to enable them to partner in safety, in whatever activity that may be.
- Healthcare professionals act as ‘first-movers’ and encourage/support patients to actively engage in safety across all levels of the system
- Care and systems are designed to support patient engagement for patient safety across all levels of the system
- Patients and Families have equal real time access to all information needed to allow them to engage in patient safety activities across all levels of the system
- If harm occurs, patients, families and healthcare professionals are supported using specially designed harmed patient care pathways to minimise further trauma
- Organisations continuously measure patient engagement in patient safety and evaluate the impact it has. Results are shared within the organisation, and between organisations, in a feedback loop
- Patient Engagement mechanisms exist for regulators, policy makers and commissioners

Patient engagement: more is needed

If we are fully to have patients engaged in patient safety, organisations in the healthcare system need to act. We are calling for:

- The health and social care system routinely to require and recognise the value of patient engagement and involvement in patient safety.
- Organisations to support patients to engage to help meet standards, goals and objectives for patient safety.
- Organisations to inform the patients, and the public, on patient safety including publishing patient safety goals, standards and metrics
- Patients to become an integral part of an organisation's governance and leadership for patient safety. They do so by working within a framework of good practice for patient engagement in patient safety.
- Organisations to develop governance and operational roles for patient engagement. These include patient engagement and involvement:
 - at the point of care
 - if harm occurs
 - in investigating unsafe care
 - in the design of service improvements
 - holding the organisation to account for delivery of patient safety standards, goals, processes and objectives.
- Organisations to fund, recruit, train and provide ongoing organisational and personal support for patient representatives and advocates
- Organisations to support their staff and leaders to have the knowledge, skills, attitudes and behaviours to engage and involve patients in patient safety
- Organisations to provide support to patient, families and staff when there is unsafe care:

- physical, mental health and social care support when it's needed
 - information and honest explanations as to what happened, what should have happened and reasons why
 - genuine and empathetic apologies
 - advice and guidance about what to expect and the options available for support and redress
- The development of three 'patient harm care pathways' for
 - Patients
 - Families / carers
 - Staff

to be used to support, inform and help whenever a death or serious incident of patient harm. These pathways to ensure that patients are actively involved at every stage of events following a harm event, including investigations.

3G. Where would patient involvement be most impactful?

(Answered in our reply to 3F above)

3H. Would a dedicated patient safety support team be helpful in addition to existing support mechanisms? If yes, how?

While we think such a team could bring some value, it is hard to see how such a team would not be seen as 'remedial' by the organisations to where they are sent.

As they would be seen as a temporary 'hit squad', we also might be concerned that while such a team would address immediate issues, it might have less effect on the systemic causes of patient safety failure. This will have the likely effect that the problems they fix may reappear after they are gone.

We do, however, suggest that a central team is required to develop methods, strategies, tools, training and support for patient advocates in local organisations so that they can help these organisations improve patient safety consistently well. This team and the patient advocates based in local organisations need to be centrally funded if they are to do these roles properly.

We strongly support cross working support groups at trust level and between trusts working together at a local level. These could then collaborate in the design of patient safety across integrated care and work with Regional networks such as the Patient Safety Collaboratives.

Q4: Initiatives

4A Do you agree with these proposals? Please give the reasons for your answer.

We note the initiatives that are being proposed and the basis of prioritisation. We suggest that such prioritisation should also be informed by patient and public engagement.

We do, however, have some comments.

We are concerned that the NHS is proposing to set targets for patient safety incident reduction by 50% for a number of named areas. We are unclear about the rationale for setting this number as a target for these areas and the evidence base behind this choice and their achievability.

Experience of other targets in the NHS mean that we worry that such targets:

- Will drive attention to these targets at the expense of other areas of patient safety concern
- Will encourage tactical – and hence temporary – fixes to demonstrate progress
- Will divert resources and attention away from other work to address the systemic causes of patient-safety failure
- May encourage ‘gaming’ of numbers which could lead to a distorted view of the state of patient safety

We would be interested to know what steps are being taken to ensure that such worries are unfounded.

We would be interested to know what resources (knowledge, skills, funding etc) will be available able to local organisations in the implementation of these initiatives.

4B Would you suggest anything different or do you have anything to add?

In Appendix A of this document you will find sets of initiatives that we propose need to be undertaken to deliver safer care.

4C. What are the most effective improvement approaches and delivery models?

While improvement techniques and tools are well known, we think that patient safety requires use of some specific approaches.

Human factors and systems thinking must be used to diagnose the systemic causes of patient safety failure. They must also be used in the design of solutions to patient safety failure.

Improvement efforts need to be directed towards the resolution of immediate patient safety problems and events, and towards the causes of shortfalls in performance metrics against performance systems standards.

The results and effect of patient safety improvement need to be tracked routinely with successes shared quickly and easily

Evidence shows that safer care requires inter-related activities and we highlight what we believe are key priorities to tackle the persistence of harm.

Our action plan for safer care comprises six inter-related themes:

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

When patient safety issues are investigated, the analysis and proposed solution(s) should consider these.

4D Which approaches for adoption and spread are most effective?

We are launching in the summer a learning platform for patient safety: The Hub.

This platform will be the engine of Patient Safety Learning. It will be a focus point for the sharing of local, national and (in time) international knowledge, skills, learning and experiences. It will foster communities of interest and practice and give people a safe place to discuss issues that may be of concern to them. It will provide a collaborative environment for people to come together, building on improvements that have already begun to adapt solutions so that they are practicable and more easily deliverable at a local level.

The learning from investigations can be discussed and the impact on organisations of applying recommendations and/ or solutions can be

analysed in a constructive way to ensure that more organisations can achieve success through their application.

It will thus act as a vehicle for people to use to support the adoption and spread of patient safety thinking and solutions.

4E. How should we achieve sustainability and define success?

In a patient-safe future, organisations:

- Have clear objectives for patient safety outcomes
- Have performance standards for patient safety outcomes, against which they measure performance. They recognise that while, in an ideal world, the ultimate standard is that no patient safety failures happen, in the real-world health care will continue to carry intrinsic risks. Therefore, organisations need to know what level of patient safety outcomes represents a good level of performance.
- Have performance objectives for how they address cases of patient safety failure, against which they set standards and measure performance.
- Use performance information to identify, track and manage specific risks to patient safety
- Performance is shown to fall short, organisations take action to address the shortfall and formally tracks the results
- Improve safety through raising patient safety standards regularly
- Share their safety performance with others
- Routinely and actively capture, assess and act on qualitative information about patient safety from all sources.
- Use data analytics to identify possible evidence of patient safety risks or potential precursors for such risks

Appendix A

Table A: Actions that need a health and social care system-wide response					
Shared learning	Professionalising Patient Safety	Patient Engagement for Patient Safety	Leadership for Patient Safety	Data and insight for Patient Safety	Culture for Patient Safety
<p>Organisations prioritise learning to improve patient safety and how they learn from:</p> <ul style="list-style-type: none"> incident investigations patients and their experiences good practice within their organisations and others evaluating their actions to improve safety 	<p>All staff are suitably qualified and experienced in patient safety:</p> <ul style="list-style-type: none"> All staff working in health and social care are trained in the foundation principles of patient safety A competency framework is developed and implemented that defines the behaviours, attitudes, skills and knowledge required for all staff to deliver safe care A curriculum for patient safety is 	<p>The health and social care system routinely requires and welcomes the value of patient engagement and involvement in patient safety. Organisations support patients to engage to help set and meet standards, goals and objectives for patient safety.</p>	<p>The health and social care system should take a 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.</p> <p>To support the development of this system wide approach, a map of health and social care organisations should be undertaken and published. The map will identify roles, responsibilities and strategic goals for patient safety and areas where further development and clarity is required</p>	<p>Health and social care systems develop models for measuring, reporting and assessing patient safety performance. This should also include qualitative data</p>	<p>Health and social care organisations to develop and publish goals to develop and sustain a Just Culture</p> <p>Health and social care organisations to implement programmes to eliminate a blame culture and introduce or deepen a Just Culture</p> <p>Health and social care organisations to measure and</p>

Table A: Actions that need a health and social care system-wide response

Shared learning	Professionalising Patient Safety	Patient Engagement for Patient Safety	Leadership for Patient Safety	Data and insight for Patient Safety	Culture for Patient Safety
<ul style="list-style-type: none"> sharing their learning with others 	<p>developed and used in the training of all staff working in health and social care</p>				<p>report their progress towards a Just Culture</p>
<p>Organisations set and deliver goals for learning from patient safety, report on progress and share widely their insights</p>	<p>Standards are developed and implemented for patient safety performance for:</p> <ul style="list-style-type: none"> Shared learning Leadership Professionalising patient safety Patient engagement Data and insight Culture 	<p>Organisations inform the patients and the public on patient safety including publishing patient safety goals, standards and metrics and their performance against them</p>	<p>Organisations should prioritise patient safety, embedding clear and published goals in their leadership and governance</p>	<p>Patient safety performance measurement models to be developed into patient safety dashboards at department, Board and system levels.</p> <p>These dashboards should include reference or baseline information that function as standards against which patient safety</p>	<ul style="list-style-type: none"> These organisational goals and programmes to be informed by: A review of how external factors (regulators / policy / commissioning / media) tolerate / support / drive blame cultures in health and

Table A: Actions that need a health and social care system-wide response

Shared learning	Professionalising Patient Safety	Patient Engagement for Patient Safety	Leadership for Patient Safety	Data and insight for Patient Safety	Culture for Patient Safety
				<p>performance can be measured and improvement / impairment be tracked.</p> <p>Dashboards to include reactive and proactive activities to support patient safety improvement.</p>	<p>social care organisations</p> <ul style="list-style-type: none"> • a review of how an organisation's current approaches to patient safety and behaviour tolerates or supports a blame culture • regular safety culture assessments of staff and patients • a review of completed serious incident investigations to determine

Table A: Actions that need a health and social care system-wide response

Shared learning	Professionalising Patient Safety	Patient Engagement for Patient Safety	Leadership for Patient Safety	Data and insight for Patient Safety	Culture for Patient Safety
					<p>how systems failures were appropriately identified and those where a person or persons were blamed as the only or primary source of failure</p> <ul style="list-style-type: none"> use of systems thinking and human factors
Organisations respond to and contribute to shared learning systems such as PSIMMs (NHSI's replacement to the NRLS) and Patient Safety Learning's Hub	Regulators require and use such organisational standards to inform their assessment of patient safety	Patients are an integral part of an organisation's governance and leadership for patient safety. They do so by working within a framework of good	An overarching leadership forum should be established for the design, coordination and delivery of safe care emphasising a systems approach and human factors	Patient safety performance data to be incorporated into risk management systems to be monitored by management teams, Boards	The design, implementation and evaluation of organisational goals and programmes to be shared for transparency,

Table A: Actions that need a health and social care system-wide response

Shared learning	Professionalising Patient Safety	Patient Engagement for Patient Safety	Leadership for Patient Safety	Data and insight for Patient Safety	Culture for Patient Safety
		<p>practice for patient engagement in patient safety. Organisations develop governance and operational roles for patient engagement. These include patient engagement and involvement:</p> <ul style="list-style-type: none"> • at the point of care • if harm occurs • in investigating unsafe care • in the design of service improvements • holding the organisation to 		and across the system.	accountability and learning

Table A: Actions that need a health and social care system-wide response

Shared learning	Professionalising Patient Safety	Patient Engagement for Patient Safety	Leadership for Patient Safety	Data and insight for Patient Safety	Culture for Patient Safety
		account for delivery of patient safety standards, goals, processes and objectives.			
Regional and local networks, such as Patient Safety Collaboratives and other geographical and professional communities are supported and strengthened to share learning and build on the 'Sign Up to Safety' networks	Guidance, resources and toolkits for patient safety are developed and shared across the wider health and social care systems to enable, encourage and support organisations and individuals to achieve higher standards of patient safety.	Organisations fund, recruit, train and provide ongoing organisational and personal support for patient representatives and advocates.	Organisations define the patient safety outcomes they want with published strategic and operational goals	Centralised systems for collecting data on patient safety incidents should include insights and learning that follow from investigation and the impact of resulting actions.	
Organisations encourage, support and remove barriers to front-line clinicians and patients to share learning and learning	In time, an accreditation framework for patient safety is developed	Patient Engagement is a core competency for staff. Organisations support their staff	Organisations have specialist patient safety experts in executive and non-executive roles on the Board	Ensure patient safety and healthcare is an integral part of AI development by, for example,	

Table A: Actions that need a health and social care system-wide response

Shared learning	Professionalising Patient Safety	Patient Engagement for Patient Safety	Leadership for Patient Safety	Data and insight for Patient Safety	Culture for Patient Safety
from others for safer care		and leaders to have the necessary knowledge, skills, attitudes and behaviours to meaningfully engage and involve patients in patient safety		engaging with the DIT's BEIS programme and others to develop capabilities to support patient safety.	
	Organisations have specialist patient safety experts to inform, support and accelerate the development and implementation of patient safety strategies and objectives. Organisations underpin these roles by a career path that encourage clinical and non-clinical staff to develop their expertise in patient safety and quality improvement	Organisations provide support to patient, families and staff when there is unsafe care: <ul style="list-style-type: none"> • physical, mental health and social care support when it's needed • support to be actively involved in investigations (to the extent 	Organisations design and implement system, processes and performance reporting to manage patient safety risks		

Table A: Actions that need a health and social care system-wide response

Shared learning	Professionalising Patient Safety	Patient Engagement for Patient Safety	Leadership for Patient Safety	Data and insight for Patient Safety	Culture for Patient Safety
		<p>they might wish to be involved)</p> <ul style="list-style-type: none"> • information and honest explanations as to what happened, what should have happened and reasons why • genuine and empathetic apologies • advice and guidance about what to expect and the options available for support and redress • support to use their experience 			

Table A: Actions that need a health and social care system-wide response

Shared learning	Professionalising Patient Safety	Patient Engagement for Patient Safety	Leadership for Patient Safety	Data and insight for Patient Safety	Culture for Patient Safety
		for learning, if desired			
	<p>Organisations and staff have access to expertise, support and advice on patient safety issues, with an emphasis on:</p> <ul style="list-style-type: none"> • developing an open and fair culture and training in patient safety • identification, management, investigation and reporting of patient safety incidents and risks • systems thinking and human factors • encouraging openness and sharing insight on unsafe care including the support and protection to whistle-blowers 		<p>Organisations use risk assessment to inform the development of patient safety goals and improvement activities including the design and implementation of solutions to prevent harm.</p>		

Table A: Actions that need a health and social care system-wide response

Shared learning	Professionalising Patient Safety	Patient Engagement for Patient Safety	Leadership for Patient Safety	Data and insight for Patient Safety	Culture for Patient Safety
	<p>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, and that training design includes follow-up and reinforcement in-work</p>	<p>Organisations seek out, welcome, and respond to all forms of patient reported safety information.</p>	<p>Integrated care systems should prioritise patient safety</p>		
		<p>Patient representatives and advocates work within appropriate governance and support arrangements.</p> <p>Patient representatives and advocates are:</p> <ul style="list-style-type: none"> recruited and trained in line with a 	<p>Standards for patient safety should be included in service commissioning and care pathway design and delivery standards for patient safety should be included in service commissioning and care pathway design and delivery</p>		

Table A: Actions that need a health and social care system-wide response

Shared learning	Professionalising Patient Safety	Patient Engagement for Patient Safety	Leadership for Patient Safety	Data and insight for Patient Safety	Culture for Patient Safety
		<p>competency framework</p> <ul style="list-style-type: none"> • given the necessary practical and emotional support to carry out their roles effectively • have clearly defined codes of conduct • are properly funded and not required to work as volunteers • employed by a central organisation that provides leadership, peer support, 			

Table A: Actions that need a health and social care system-wide response

Shared learning	Professionalising Patient Safety	Patient Engagement for Patient Safety	Leadership for Patient Safety	Data and insight for Patient Safety	Culture for Patient Safety
		guidance, training and skills			

Table B: Actions that Patient Safety Learning will take

Shared learning	Professionalising Patient Safety	Patient Engagement for Patient Safety	Leadership for Patient Safety	Data and insight for Patient Safety	Culture for Patient Safety
Patient Safety Learning will publish a detailed report on shared learning to help take action for improving patient safety	Patient Safety Learning will publish a detailed report on professionalising patient safety to help take action for improving patient safety,	Patient Safety Learning will publish a detailed report on patient engagement and involvement in patient safety to help take action for improving patient safety,	Patient Safety Learning will publish a standalone report for leaders to use to help take action to define, develop, support and maintain leadership for patient safety	Patient Safety Learning will publish a detailed report on data and insight to help take action for improving patient safety	Patient Safety Learning will publish a detailed report on just culture to help take action for improving patient safety,

Table B: Actions that Patient Safety Learning will take

Shared learning	Professionalising Patient Safety	Patient Engagement for Patient Safety	Leadership for Patient Safety	Data and insight for Patient Safety	Culture for Patient Safety
<p>Design, develop and implement a knowledge repository and communities for learning on patient safety: The Hub. Patient Safety Learning will:</p> <ul style="list-style-type: none"> • Promote, encourage, and support the use of the Hub by all users • Explore ways for organisations to use and support the Patient Safety Learning Hub • Develop communities within and beyond the Hub 	<p>Work with others to develop standards for patient safety including their use by regulators, commissioners, service providers etc</p>	<p>Develop a model and governance for patient engagement and advocacy for patient safety for service providers, regulators, commissioners etc</p>	<p>Work with others to define and develop a leadership model for patient safety in healthcare, including standards, training, governance, measurement and reporting</p>	<p>Convene a symposium of experts, expert users and patients to start identifying the critical data and insight needed to measure, monitor and determine effective action for patient safety</p>	<p>Provide, on the Hub and elsewhere, tools, case studies and resources to help organisations and teams learn, adopt and assess just culture</p>

Table B: Actions that Patient Safety Learning will take

Shared learning	Professionalising Patient Safety	Patient Engagement for Patient Safety	Leadership for Patient Safety	Data and insight for Patient Safety	Culture for Patient Safety
<ul style="list-style-type: none"> • Explore rapid patient safety information sharing • Connect the Hub to other sites to give our users the widest possible access to learning • Curate, commission and develop content 					
<p>Celebrate learning from patient safety success through the Patient Safety Learning Awards.</p>	<p>Work with others to develop a competency framework for patient safety and implementation programmes</p>	<p>Initiate the development of three 'patient harm care pathways' for</p> <ul style="list-style-type: none"> • Patients • Families / carers • Staff <p>to be used whenever a death</p>	<p>Work with others to help design and develop and establish an overarching forum for the design, coordination and delivery of safe care emphasising a systems approach and human factors</p> <p>Support this forum as it leads on the design, promotion, coordination, delivery and evaluation</p>	<p>Make recommendations for system-wide data and measurement for patient safety including organisational dashboards</p>	<p>Promote a just culture in everything we do and across all our communications and engagement</p>

Table B: Actions that Patient Safety Learning will take

Shared learning	Professionalising Patient Safety	Patient Engagement for Patient Safety	Leadership for Patient Safety	Data and insight for Patient Safety	Culture for Patient Safety
		or serious incident of patient harm occurs	of leadership for safer care.		
<p>Review current investigative practice to understand how / if health and social care organisations are learning from harm and turning recommendations into action.</p> <p>We will publish our review and recommend action</p>	<p>Develop and provide training support to address gaps in patient safety skills, knowledge, attitudes and behaviours</p>	<p>Work with others to promote, share, implement and evaluate the models for patient engagement in patient safety</p>	<p>Explore with health and social care organisations how critical leadership decisions are more explicitly and routinely risk assessed for patient safety. Explore the value of using decision support tools such as safety business cases</p>	<p>Develop associated tools such as ‘how to’ guides, maturity models and self-assessments frameworks to support organisational leadership</p>	<p>Support health and social care organisations through support and practical training</p>
<p>Patient Safety Learning will analyse and publish an assessment of how organisations are prioritising patient safety. This will be assessed through the:</p>	<p>Develop with others an accreditation framework for patient safety</p>		<p>Develop tools such as ‘how to’ guides, maturity models and self-assessment frameworks to support organisational leadership for patient safety</p>		

Table B: Actions that Patient Safety Learning will take

Shared learning	Professionalising Patient Safety	Patient Engagement for Patient Safety	Leadership for Patient Safety	Data and insight for Patient Safety	Culture for Patient Safety
<ul style="list-style-type: none"> • review of whether health and social care organisations publish and report on their patient safety goals • information publicly available on patient safety performance including new Patient Safety Dashboards • insight derived from the Hub 					
Support health and social care organisations to through support and practical training	Support health and social care organisations through support and practical training	Support health and social care organisations through support and practical training	Explore with key social care leaders what their safety challenges are. Use this insight to inform safety system and human factors approaches in integrated care	Work with health and social care data providers to design programmes to implement patient safety performance	

Table B: Actions that Patient Safety Learning will take

Shared learning	Professionalising Patient Safety	Patient Engagement for Patient Safety	Leadership for Patient Safety	Data and insight for Patient Safety	Culture for Patient Safety
				management and measurement	
			Support health and social care organisations through support and practical training	Support health and social care organisations to address specific patient safety knowledge and skills gaps through support and practical training	
			Support health and social care organisations through support and practical training	Support health and social care organisations to address specific patient safety knowledge and skills gaps through support and practical training	

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

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