

# Patient Safety, apps and the patient's perspective

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patient  
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learning



# 20 years of initiatives but still too many patients suffer harm

- 5% hospital patients suffer avoidable harm
- 3.6% of hospital deaths, >50% avoidable
- More than 150 deaths a week
- Annually £2.2bn litigation plus £2.5bn cost of unsafe care
- 15% of costs are attributable to unsafe care: OECD
- Families and staff also suffer

# Why is patient harm a persistent problem?

- A failure to learn
- Few safety standards, not consistently applied
- Staff are not provided with skills & knowledge
- Lack of system leadership for safety
- Patients are not engaged in their safety
- Poor data and reporting
- Blame culture and fear

# Our vision: 'Towards a patient-safe future'

- Clinicians, patients and leaders share learning
- Everyone is suitably qualified and experienced
- A culture that promotes learning and prizes safety
- Measurement & reporting drives safety improvement
- Organisations take 'reasonable and practical steps'
- Patients are actively engaged

## A Patient-Safe Future

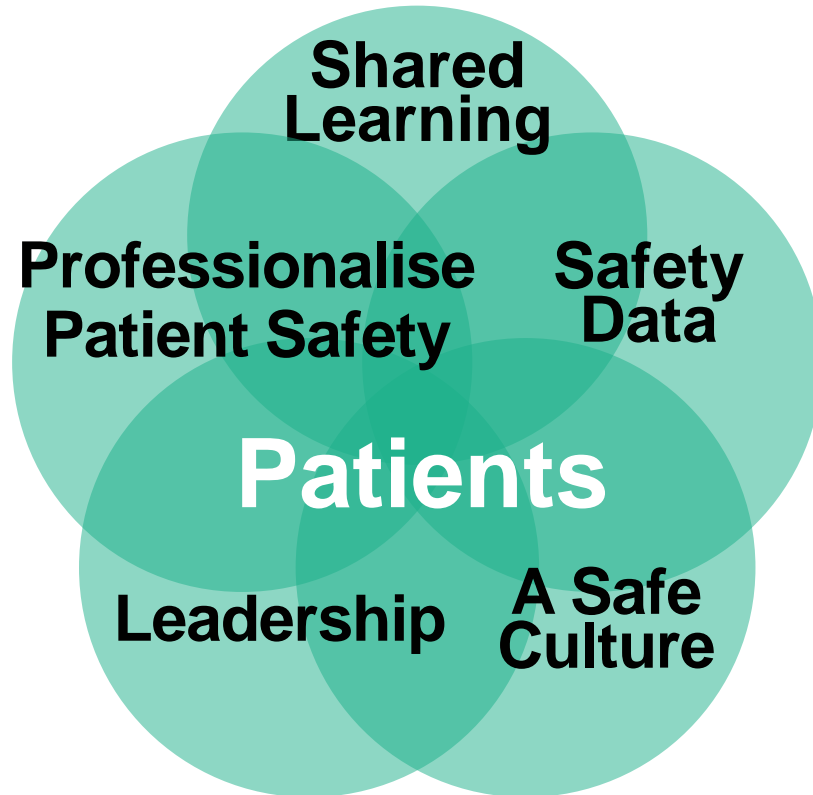
A Patient Safety Learning  
Green Paper

September 2018

# New ways of thinking and action are needed

- Systems and human factors
- Shared learning in healthcare and from other safety sectors
- Patients and the public as partners in safety
- Design in safety - not just addressing harm
- Use of technology for safer care

# Blueprint for action for a patient safe future



# Shared Learning and *the hub*



- Online learning platform and communities
- For everyone: clinicians, patient safety managers, researchers and patients
- To share learning and knowledge
- First dedicated learning platform for patient safety

# Data and insight



- Better ways of measuring & reporting patient safety performance – ‘secrecy is insane’\*
- Safety comparison data to drive out variation
- Not just data on harm but to answer ‘are we safe’
- Patient Safety dashboards for every organisation
- Symposium of experts on patient safety data



# Partnership with patients



- At the point of care – information is key
- When things go wrong
  - ‘Patient harm care pathways’ for patients, families & staff
  - Learning from harm
- Patient advocacy with support & governance
- Holding the system to account

# How digital can improve healthcare

- Freeing up time and resources – clinicians and process
- Better data, shared and AI
- Up-to-date patient information
- Earlier diagnosis
- Opportunities for patient and public engagement
  - Self managed care
  - Better understanding of health conditions and prevention
- Internet of things

# NHS Plan and technology

- Joined up health and care record
- Patients to have access to care plan via NHS App
- Systems to support population health management
- Digital first primary care offer
- Fully digitised secondary care

# ECRI mobile health 4<sup>th</sup> highest ps concern

- Lack of regulation of new technologies
- Barriers to ensuring providers are accurately receiving data a device collects
- Concern that patients not using the technology correctly or at all
- Faulty information or missing test results - predisposed to making a diagnostic error

# Digital patient safety issues

- No 'generic patient'
  - Health and technology literacy
  - Comorbidities
- Can all users properly consent e.g. use of data for AI, in apps, in predicting future health
- Who sets the standards, who regulates?

# Patient safety questions in app design

- Are the standards for care designed for patient safety?
- Will patient safety information be made available to help others?
- Does this app support or enable patient safety?
- Does this app help patients engage for safer care?
- Has the patient perspective been taken into account?
  - Understanding of context -multi-morbidities e.g. fitness app for anorexics
  - Unintended consequences in use
  - Potential adverse interactions between apps
- Does the app design reflect human factors thinking?

# Patient safety questions in app use

- Are providers accurately receiving the data collected?
- Does a patient's GP know whether they're using an app and how?
- Who is responsible for responding to patients' questions?
- Who is responsible for patient safety?
- Is the feedback on apps mainly to product developers; does it focus on use and patient safety?
- Does the apps consider multi morbidities?
- Is all tech supported: is it backwards compatible; can patients access to safety data?

# Apps and Patient Safety: Safer Systems for Better Care

IT patient engagement tools offer many potential benefits

Unintended consequences, such as threats to patient safety, have not been adequately studied or assessed

Urgent need to:

Inform the design, implementation and use of such tools

- Design in patient safety with human factors as integral
- Set and regulate standards for app patient safety
- New NICE clinical efficacy guidelines should consider patient safety
- Need reporting and shared learning for:



# How Patient Safety Learning can help

- *the hub*
  - Professionals and patients to share views on apps and patient safety
  - Shared learning from apps
- Call for patient safety standards and regulation
- In app design and use
  - Promote system thinking and human factors in design
  - Promote patient engagement for safe use
- Suggestions welcome

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