

Reviewing Priorities to Improve Patient Safety at the National Level

Presentation to ONECPD

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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

What will a
patient-safe
future look like?



Our vision: 'Towards a patient-safe future'

- Patient Safety is a core purpose
- Clinicians, patients and leaders share learning
- Standards with suitably qualified & experienced staff
- Strengthened leadership and governance; 'reasonable and practical steps'
- Patients are actively engaged
- Better measurement & reporting with a culture that promotes learning and prizes safety



A Patient-Safe Future

A Patient Safety Learning
Green Paper

September 2018



A Patient-
Safe Future:
A Blueprint
for Action

White Paper

We need to think
differently about
patient safety.



New ways of thinking and action are needed

- Systems and human factors
- Shared learning
- Support the 'front line' deliver safer care
- Patients and the public as partners in safety
- Design in safety - not just addressing harm
- Use of technology for safer care

Unsafe care has systemic causes



Who could fix this? Who should?

- The Anesthetist?
- The surgical team?
- The Board?
- Executives – in role and as a team?
- Risk manager/Patient Safety Manager?
- Commissioners/funders?
- Regulators – CQC, Professional bodies/Royal Colleges?

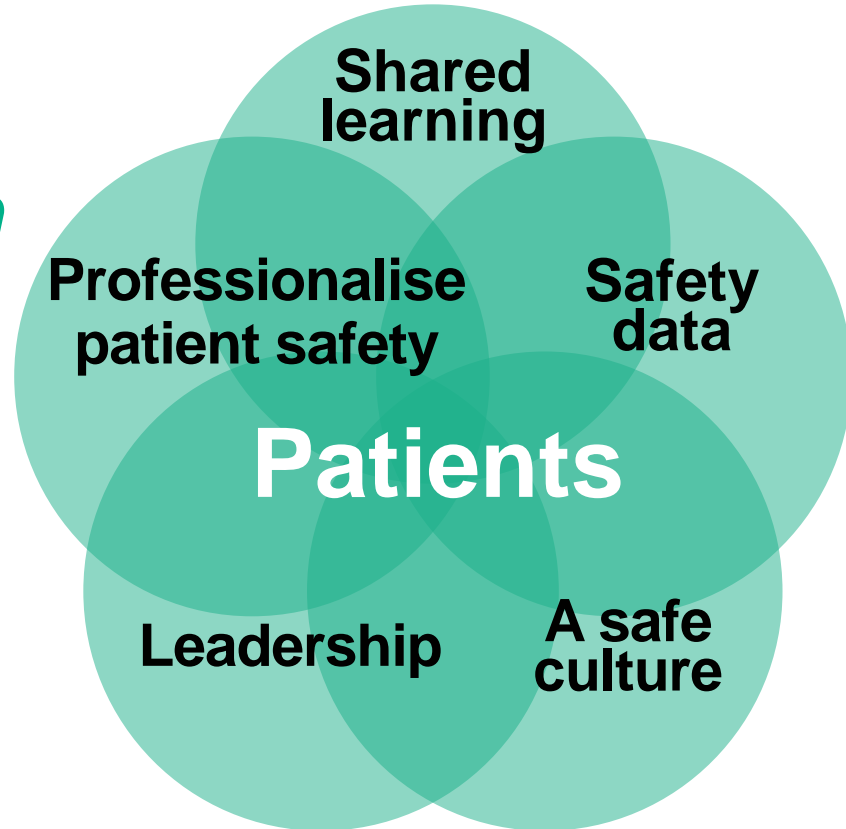
We should consider systems issues and human factors

- Who decided to switch majors to the afternoon?
- Impact on patient safety?
 - What assessment? What outcome?
- Patient engagement and consent
- Were staffing levels assessed and changed?
- Impact on culture?
- What factors would an SUI investigation identify?
- What recommendations?

We aim to help
people think
differently about
patient safety.



We propose a
Blueprint for Action
for a patient-safe
future



We have to act to *share learning* for patient safety



- Organisations should have goals to share learning
- Innovation and good ideas are shared
- Knowledge spreads quickly and easily
- People find answers to their patient safety questions
- People don't reinvent the wheel
- Access to proven tools and resources
- Information is shared and used by patients/public

the hub is an online platform for learning and communities



- Learning from investigations – Patient Safety Learning Inquiry
- First dedicated learning platform for patient safety
- For clinicians, patient safety managers, researchers & patients
- A repository of ideas, tools, case studies & good practice
- Communities of interest
- Patient safety news and stories

We need to *professionalise* patient safety



- A competency framework for all staff
- Standards for patient safety
- Guidance, resources and toolkits
- Patient safety expertise
- Investigations for learning and prevention
- Implementation

We need better *leadership* for safer care



- Patient safety is a strategic *purpose*
- Patient safety goals, standards and metrics
- System-wide response to safety: forum of leaders
- Effective governance and expertise for patient safety
- Integrated care systems to prioritise patient safety
- Investigations are fit for purpose

We have to *engage patients* for patient safety



- At the point of care – information and escalation
- Education, training and support for staff
- 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

We need *data and insight* to understand if and how we are safe



- Safety comparison data to drive out variation
- More thinking is needed: symposium of experts and users on patient safety data
- Patient safety dashboards – quantitative and qualitative

We need to replace blame culture with a *just culture*



- We must eradicate blame and fear
- Prioritise programmes to eliminate a blame culture and introduce or deepen a just culture
- Measure and report progress towards a just culture

We need to *work in partnership* for a patient-safe future

- Commissioners and providers of health and social care
- System and professional regulators
- Policy makers
- Parents and families
- Politicians
- Professional associations
- Clinical leaders
- Patient charities
- Human Factors experts

Help create the patient-safe future

- Support our patient-safe future proposals
- Engage with us on *the hub*
 - Provide content
 - Join a community
 - Share learning
 - Become a topic expert
 - Share your experiences from the ‘front line’

What questions or comments do you have?

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