A Blueprint for Action

A New Strategy for Patient Safety – Insight, Involvement, Improvement Conference

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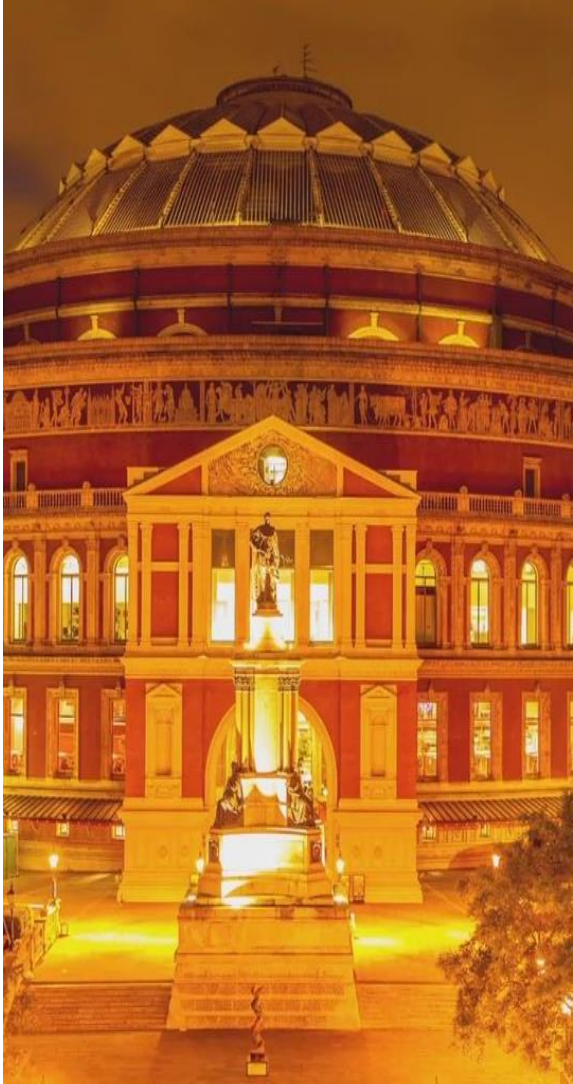
Chief Executive

patient safety learning

patient safety learning

20 years of initiatives but still too many patients suffer harm



Why is patient harm a persistent problem?

- Safety is one priority of many
- Few safety standards
- Not designing safe systems
- Blame culture and fear
- Patients not engaged
- Lack of leadership
- Failure to learn and act

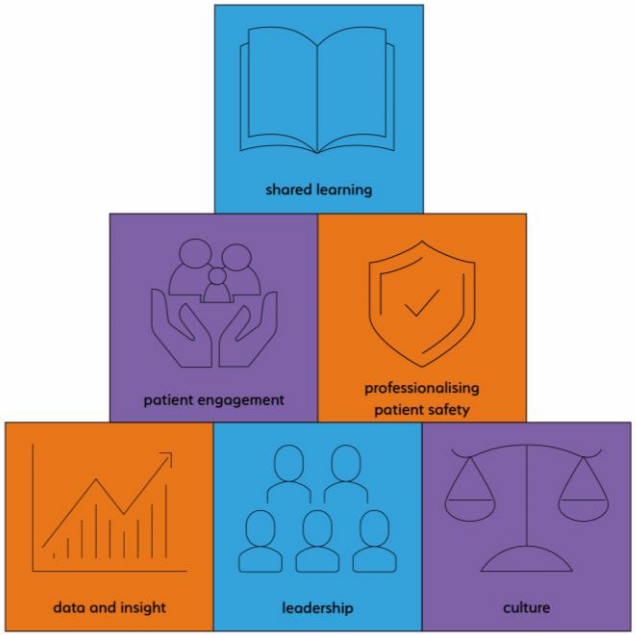
What we're doing isn't solving the problem

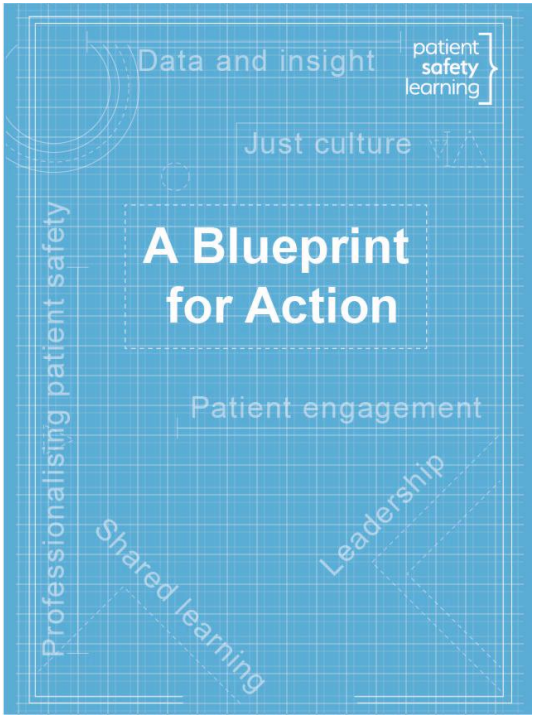
- A focus on sharing learning from good practice and experience
- To design for safety, not just address harm

A patient-safe future: safer for patients, service users and staff

- Patient Safety is a core purpose
- Standards
- All staff ‘suitably qualified and experienced for safety’
- Patients as members of the team
- A culture that prizes safety and promotes learning
- Learning is shared and applied quickly and easily

Six foundations of a patient-safe future





patient safety learning

L*eadership* for safer care

- Patient safety goals, standards and metrics
- Forum of leaders and governance
- Design for safety not just respond to harm

Professionalise patient safety

- Standards for patient safety
- A competency framework for all staff
- Patient safety & human factors expertise
- Investigations for learning and acted upon
- Address the ‘Implementation gap’

Accreditation for patient safety

Engage patients for patient safety

- At the point of care
- When things go wrong
  - Care pathways for patients, families & staff
- Patient advocacy with support & governance
- Holding the system to account

Data and insight for safety

- Safety comparison data to drive out variation
- Patient safety dashboards
  - Quantitative
  - Qualitative including stories and case studies
- Symposium of experts and users

Replace blame culture with a *Just Culture*

- Programmes to eliminate a blame and fear
- Measure and report progress
- Leaders model the behaviour we want to see
- A just *learning* culture

“To err is human, to cover up is unforgiveable and to fail to learn is inexcusable.”
Sir Liam Donaldson

Our *Blueprint for Action* recommendations:

- Organisations should have goals to share learning
- Knowledge and innovation should be shared readily
- Should be easy to find answers to questions
- Access to proven tools and resources

the hub: online platform for patient safety

- A free repository of knowledge
  - ideas, stories, tools, case studies, good practice
- Communities
- Patient safety news and stories
- Personalised resources and topics
- Hosted events and webinars
- For everyone – clinicians, patients, patient safety experts etc

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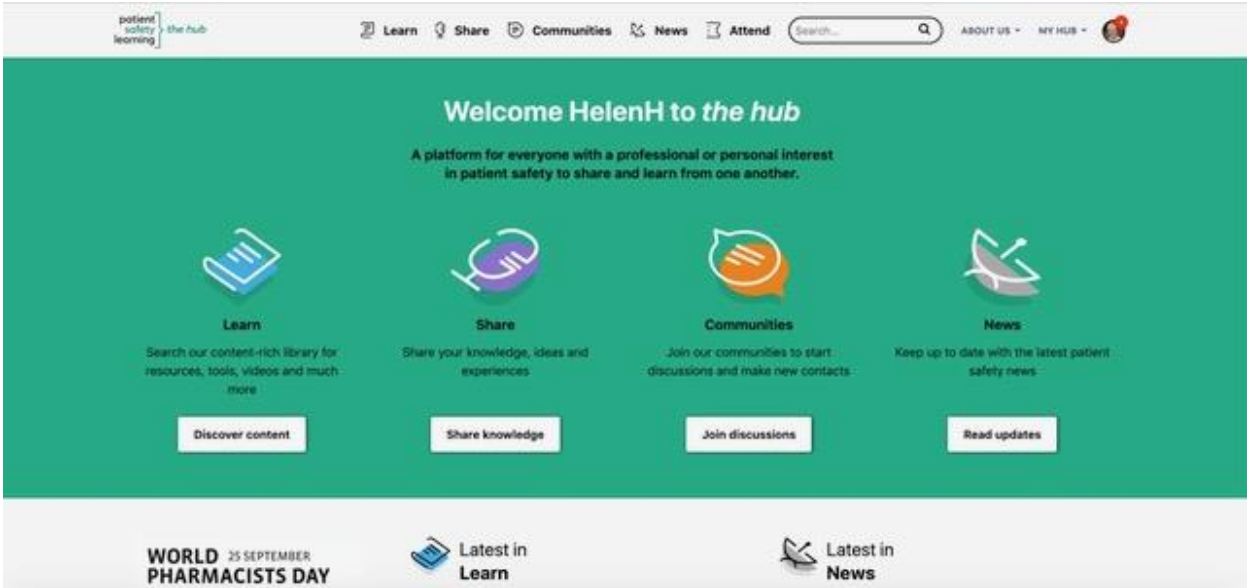
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