

Browne Jacobson
New Patient Safety Strategy Event

18th November 2019

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One team shared values



The 3 Is

- Insight (data)
 - Involvement (patients and staff)
 - Improvement (QI methodology and national Ps programmes)
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- Safety I and Safety II

One team shared values



Context

- New landscape of:-
 - ❖ Understanding and using data to inform
 - ❖ Focus on Improvement
 - ❖ Less is more re investigations
 - ❖ Compassionate Leadership
 - ❖ Just Culture

One team shared values



Joining Up Systems and Processes

- Learning From Deaths and the ME system
- NAPSAC
- IP safety
- Learning disabilities
- Claims and litigation
- Subject specific safety issues (maternity, medicines etc)

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Key Ingredients

- Psychological safety for staff
- Diversity
- Compelling vision
- Leadership and teamwork
- Open to learning

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Patient Safety Specialists

- Key leaders in safety systems
- Oversight of PS activity within their organisation
- Visible and credible re PS
- Able to support PS at organisation level (i.e. DIPAC)
- Future professionalisation of the role
- Accreditation
- Ensure HF, just culture & systems think embedded into all PS activity

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Patient Safety Syllabus

- Develop a robust, achievable and aspirational plan for patient safety training for the NHS
- Make safety training within professional educational programmes explicit and mapped to the competencies in a national syllabus
- Ensure every member of the NHS has access to patient safety training; from ward to board and from commissioner to provider.



Personal Reflections

- Right direction of travel
- Much better triangulation and links with other processes
- Good vision and ambition – BUT
- Light on detail
- Slow on further supporting information
- Unclear re resources to deliver ambition
- Opaque structures to support delivery

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Any questions?



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