

Patient Voice Engagement

SEHTA International MedTech Expo &
Conference 2023

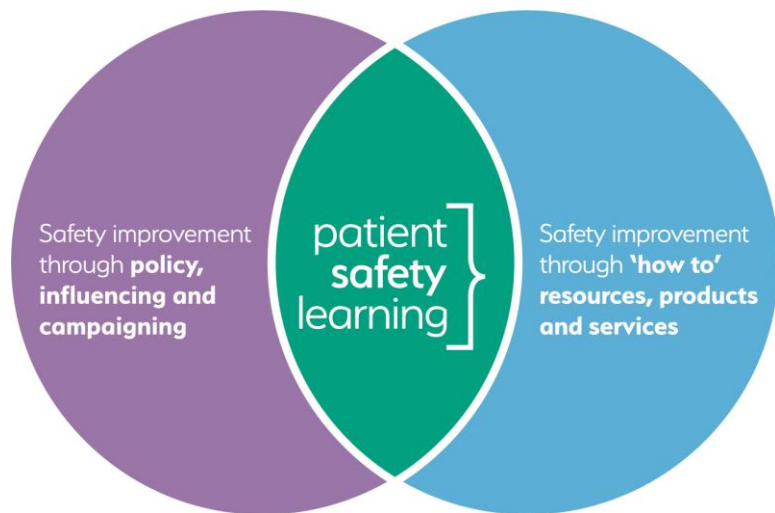
Helen Hughes, Chief Executive of Patient Safety Learning

Friday 3 November 2023



Patient Safety Learning

- Founded 2018
- A charity and independent voice for patient safety
- Listening, learning and promoting the voice of the 'patient safety front line'
- Mission & Purpose
 - To transform how health & social care organisations think & act in regard to patient safety
 - Patient safety as a core purpose



Scale of avoidable harm in healthcare

In high income countries, WHO estimates

1 in 10

patients are harmed while receiving hospital care –
50% of which is preventable

15%

of healthcare costs are attributable to unsafe care

Unsafe care is one of the

top 10 causes

of death and disability worldwide

11,000+

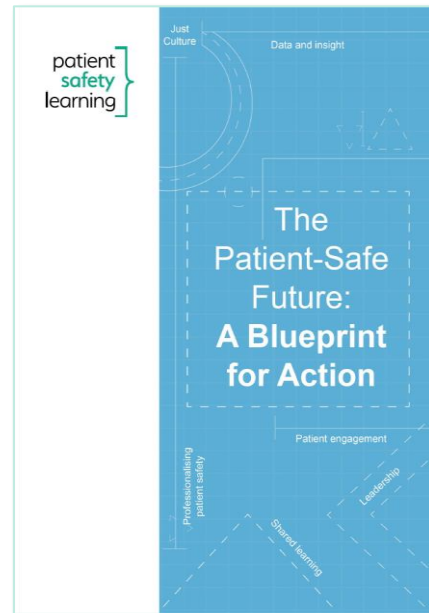
avoidable deaths each year

- Patients want safe and effective care
- Patients assume patient safety is a priority until they experience avoidable harm
- Despite the efforts & good work of many people, unsafe care continues to persist
- Have we normalised an unsafe system?

Why does avoidable harm persist?

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

Healthcare needs to operate as an effective safety management system; safety as a core purpose



Engaging patients for patient safety

The day aims to influence stakeholders to work collaboratively towards **co-designing health care policies and safety interventions** that truly reflect the needs and preferences of patients.

- At the point of care
 - shared decision making
 - informed consent
- For learning and redress
 - if things go wrong
- For change and improvement
- For advocacy and accountability




At the Point of Care: 5 Moments of Medication Safety



When things go wrong: Derek Richford


- We need leaders that say:
 - We made a mighty mistake and we're sorry.
 - We'll do something about it.
- We need people 'real-life' people who can represent the patient perspective at local board level and right up to the top of the NHS.
- We need the NHS to actively help make it easier for people to engage.




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“Getting the hospital to be honest with us felt like a battle from day one.” An interview with Derek Richford


[Posted by Patient Safety Learning on 13 September 2023](#)


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Summary

Derek Richford's grandson Harry died in 2017 at just a week old. Since Harry's death, Derek has worked tirelessly to uncover the truth about what happened at East Kent Hospitals University Foundation Trust (EHUFT) to cause Harry's death. His efforts resulted in a three-week Article 2 Inquest that found that Harry had died from neglect. In addition, the Care Quality Commission (CQC) successfully prosecuted the Trust for unsafe care and treatment and Derek's work has contributed to a review into maternity and neonatal care services at EHUFT.

In this interview, we speak to Derek about how EHUFT and other agencies engaged with his family following Harry's death. As well as outlining how a culture of denial at the Trust affected his family, he talks about individuals and organisations that acted with respect and transparency. He highlights what still needs to be done to make sure bereaved families are treated with openness and dignity when a loved one dies due to avoidable harm.

Content

Hi Derek, thank you for speaking to me today.

Firstly, can you describe the attitude of managers and senior clinicians at the Trust towards your family after Harry's death?

Leaders and staff at EHUFT were closed off to us from the beginning. At every step, it very much felt like they were saying, “There's nothing to see here.” Looking back, I realised very soon that Harry's birth that we needed to start documenting what was happening because the Trust was not being honest. When I arrived at the hospital, we asked a nurse for the name of the doctor who had overseen my daughter-in-law Sarah's care, and a while my son Tom had expressed concerns about the nurse told us, “You can't have that information. It's confidential.” At that point I started photographing Sarah's notes as I wanted to make sure we had a record.

Once the Trust's internal investigation into Harry's death started, they told us they couldn't talk to us while it was ongoing. When we said that they wanted to contribute, we were totally shut out. It was

RELATED HUB CONTENT

University Hospitals Birmingham: Half of staff felt bullied Latest comment by **Patient Safety Learning**

Chair who was ‘not always honest’ in old job gets NICE's full support Latest comment by **Patient Safety Learning**

Every time I was in operating theatre, I felt that I was just ‘out of control’ Latest comment by **Patient Safety Learning**

USEFUL EXTERNAL LINKS

[Harry's Story](#)

[Patient / Family support](#)

[Patient story](#)

[Accountability](#)

[Transparency](#)

[Speaking up](#)

[Duty of Candour](#)

[Investigation](#)

[Organisational culture](#)

[NPSDs](#)

Patient voices in a fragmented patient safety landscape

National improvement agencies and programmes <ul style="list-style-type: none"> NHS Horizons AQUA Getting it Right First Time (GIRFT) NHS Impact 	Government and Parliament <ul style="list-style-type: none"> Department of Health and Social Care Health and Social Care Select Committee 	Standard setting bodies <ul style="list-style-type: none"> Medical Royal Colleges National Institute for Health and Care Excellence Professional Record Standards Body 	Providers <ul style="list-style-type: none"> Acute Trusts Ambulance Trusts Mental Health Trusts Community Health Trusts Primary care organisations Primary care networks
Ombudsman <ul style="list-style-type: none"> Parliamentary and Health Service Ombudsman 	National coordinating groups <ul style="list-style-type: none"> National Quality Board National Patient Safety Committee 	Regional and local area bodies <ul style="list-style-type: none"> NHS England Regional Teams Integrated Care Systems AHSNs and patient safety collaboratives Healthwatch Coroners 	System and professional regulators <ul style="list-style-type: none"> Care Quality Commission Medicines and Healthcare products Regulatory Agency Individual regulators of healthcare professionals Health and Safety Executive
Patient safety bodies <ul style="list-style-type: none"> Healthcare Safety Investigation Branch Patient Safety Commissioner for England National Guardian's Office 	National NHS bodies <ul style="list-style-type: none"> NHS England National Patient Safety Team NHS Resolution 	Individuals <ul style="list-style-type: none"> Healthcare professionals Board members and non-executive directors Governors Medical Examiners Patient Safety Specialists Patient Safety Partners Freedom to Speak Up Guardians 	

Failure to investigate, learn and provide redress to patients and families

- Repeated failure to involve family members and carers in investigations following avoidable and unexpected deaths
- Highlighted again in last year's East Kent Maternity Review:
 - Family members excluded & marginalised after serious events
 - Unwillingness to engage with families in investigations
 - Distress and a basic lack of kindness and compassion
- Harmed Patient Alliance
 - 'Unimaginable' and 'unnecessary' distress caused to families with poor investigations and coverups
 - Minimising compounded harm should be a national patient safety priority, with research and policy efforts looking wider than Duty of Candour and involvement in investigations

Reading the signals

Maternity and neonatal services
in East Kent – the Report of the
Independent Investigation

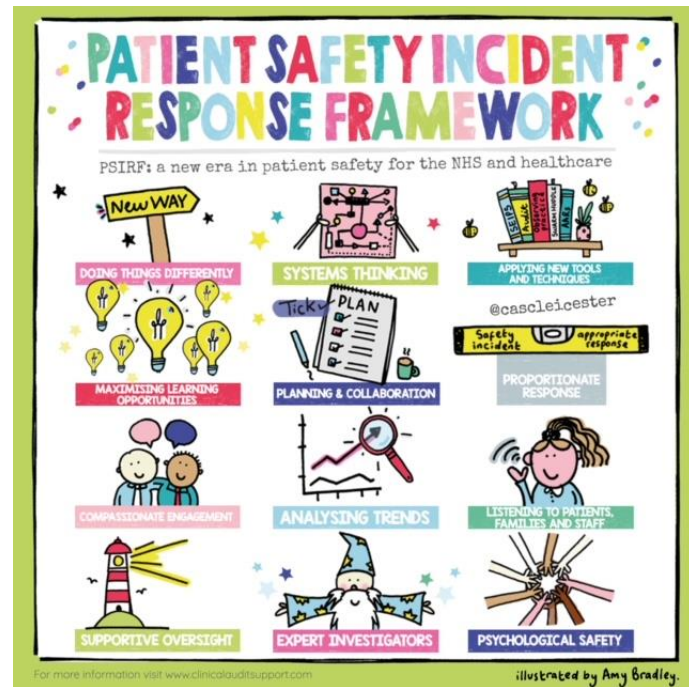
October 2022

Dr Bill Kirkup CBE

HC 661

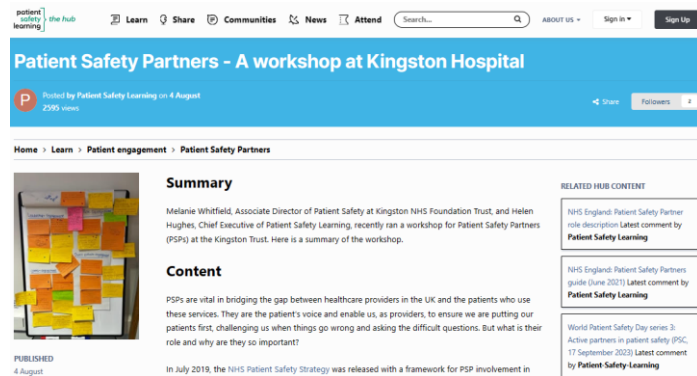
NHS Patient Safety Incident Response Framework

- New NHS approach to responding to patient safety incidents, 4 aims:
 1. Listening to patients, families and staff involved in incidents with respect and care, involving them meaningfully throughout the process
 2. Using systems tools to help understand all the factors that have contributed to an incident
 3. Actions that are appropriate for the seriousness and outcome of the incident
 4. Making sure that lessons learned from investigations lead to improvement and the prevention of future harm
- Role of Patient Safety Partners



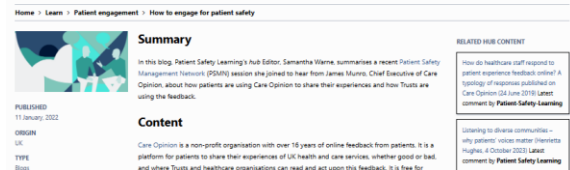
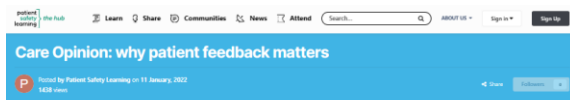
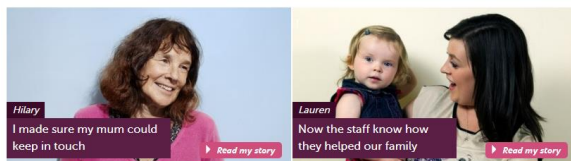
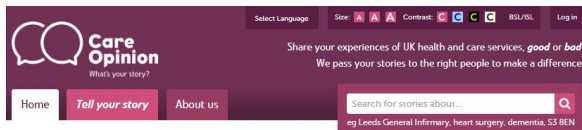
Patient Safety Partners

- Enabling patients to support and be involved in wider governance and leadership of safety activities, including:
 - Membership of safety and quality committees
 - Working with organisation boards
 - Involvement in staff patient safety training
 - Participation in investigation oversight groups
- On *the hub* we host the peer support Patient Safety Partner Network.

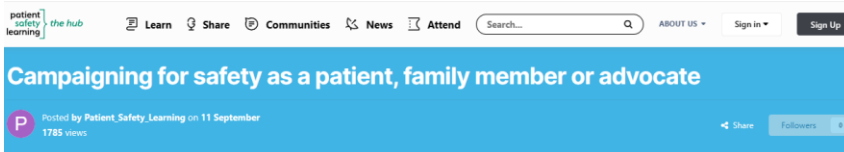


Patient engagement for Change and Improvement

Care Opinion

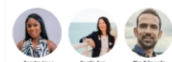


the hub (www.pslhub.org)



Home > Learn > Patient engagement > How to engage for patient safety

Campaigning for safety as a patient, family member or advocate



Summary

In this video we hear from three people campaigning for patient safety improvements:

- Sandra Igwe – CEO of the Motherhood Group.
- Tim Edwards – campaigner for improvements in pulmonary embolism care and diagnosis.
- Soojin Jun – co-founder of Patients for Patient Safety US.

They talk about their experiences of engaging with the system, the challenges they have faced and offer advice for others seeking to campaign for change in healthcare.

The insights they share help evidence the need for healthcare organisations and frontline staff to work with patients, their families and campaigners in improving safety and reducing inequalities.

Content

This video has been produced in support of World Patient Safety Day 2023 and the chosen theme of 'Engaging patients for patient safety'.



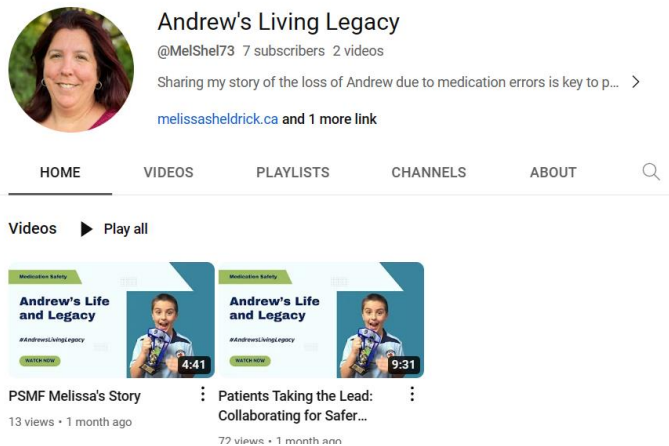
RELATED HUB CONTENT

The future of engaging patients and families for patient safety (15 September 2023) Latest comment by **Patient Safety Learning**

Speak Up Campaigns! Latest comment by **Patient Safety Learning**

NHS England: The Learn from Patient Safety Events (LPPSE) service – patient and family discovery report (13 October 2023) Latest comment by **Mark Hughes**

Success stories of patient engagement in patient safety



- Andrew's Life and Legacy
 - Supporting the implementation of continuous quality improvement in community pharmacies
 - Including anonymous error reporting
 - Legislative and policy changes across Canada
 - So others are not harmed
- Martha's rule – a right to a 2nd opinion

For advocacy and accountability

- World Patient Safety Day Webinar
- Panellists:
 - Dr Henrietta Hughes, Patient Safety Commissioner for England
 - Jono Broad, Patient leader and a member of the South West Personalised Care Team
 - Helen Hughes, Chief Executive of Patient Safety Learning
 - Tracey Hanson, Patient Safety Partner at Central and North West London NHS Foundation Trust

The screenshot shows the Patient Safety Learning website interface. At the top, there's a navigation bar with links for Learn, Share, Communities, News, and Attend, along with a search bar and user options like Sign In and Sign Up. The main header features the title "World Patient Safety Day webinar: Engaging patients for patient safety (15 September 2023)" in a blue banner, with a sub-header indicating it's "Hosted by Patient Safety Learning on 27 September" and "803 views". Below the banner, a breadcrumb trail reads "Home > Learn > Patient engagement > How to engage for patient safety". The content area is divided into three columns. The left column includes a video thumbnail titled "Elevate the role of Patients for patient safety" and metadata: PUBLISHED 27 September, ORIGIN UK, TYPE Seminars and presentations, CONTENT TYPE News, SUGGESTED AUDIENCE Everyone, and TAGGED with Patient engagement, Collaboration, Speaking up, Communication, Accessibility, and Harmed Care Pathway. The middle column has a "Summary" section describing the webinar's focus on engaging patients for patient safety, followed by a "Content" section featuring a video player for the "Webinar: Engaging patients for patient safety" scheduled for Friday 15 September 2023. The right column, titled "RELATED HUB CONTENT", lists two related articles: "NHS England: John's story - World Patient Safety Day 2023, engaging patients for patient safety" and "NHS England: World Patient Safety Day 2023 bite-size videos - Engaging patients for patient safety in the NHS". At the bottom right, there's a "USEFUL EXTERNAL LINKS" section with a link to "Patient Safety Commissioner".

Patient Safety Standards: Patient engagement is a Core Foundation

- Seven Foundations for action & safety priorities + 26 underpinning Aims
 - Practical actions to address the foundations of safer care for patients
 - Underpinned by systemic analysis & evidence
 - Based on “*A Blueprint for Action*”



Leadership and governance

1. Patient safety is a core purpose
2. Patient safety is embedded in governance
3. Organisation has a patient safety plan
4. New services are designed for safety
5. System leadership
6. Organisational leadership for patient safety



Culture

7. Patient safety culture tackles blame and fear
8. Promotes patient safety improvement
9. Role of HR



Shared learning

10. Learning goals for improving patient safety
11. Learning from near misses
12. Learning from investigations
13. Learning from feedback and complaints
14. Learning from others
15. Shares learning with others



Professionalisation of patient safety

16. All staff are suitably qualified and experienced
17. Specialist skills in patient safety and human factors



Patient engagement

18. Commitment to patient engagement
19. Organisational systems for engaging with patients
20. Patient engagement in their own care
21. Patient engagement if things go wrong
22. Patient engagement for safer care



Data and insight

23. Metrics and data to measure and manage patient safety

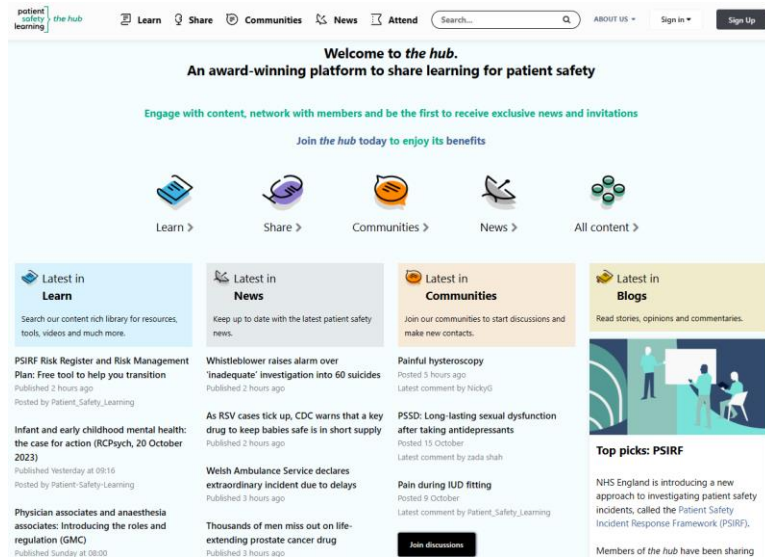


Delivery of patient safety services

24. Services are delivered safely
25. Workforce planning
26. Workforce deployment

the hub at Patient Safety Learning

- Sharing knowledge for learning & action via our online platform
- Publishing & promoting high quality content that can be shared to improve patient safety
- Promoting patient safety good practice & policy
- Universally available free resource
- **Voices of patients and families**



Work with us to create a patient safe future

- Learn & share
- Join a community
- Become a topic expert
- Share your experiences
- Patient Safety: a social movement
 - Email: helen@patientsafetylearning.org
 - Website: www.patientsafetylearning.org
 - Twitter: [@ptsafetylearn](https://twitter.com/ptsafetylearn)
 - LinkedIn: [Patient Safety Learning](https://www.linkedin.com/company/patient-safety-learning)

