Patient Voice Engagement

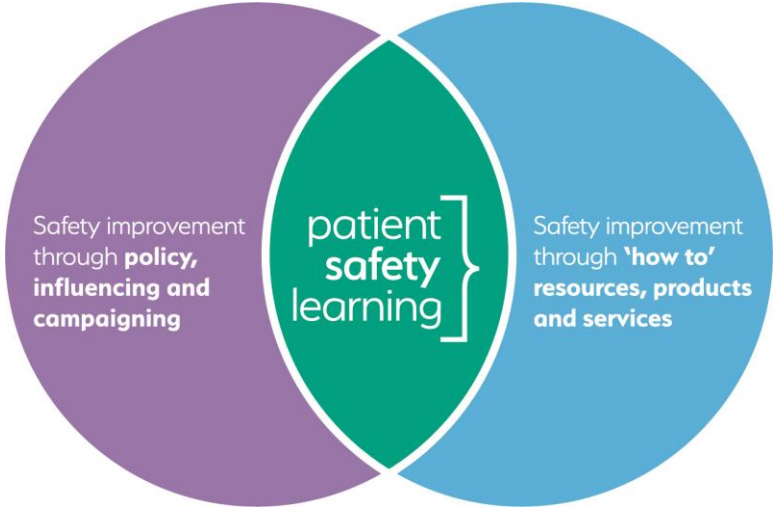
SEHTA International MedTech Expo & Conference 2023

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



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Scale of avoidable harm in healthcare

- 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?

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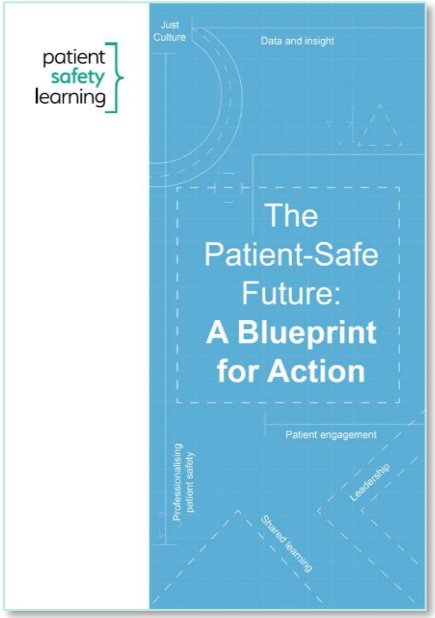
Why does avoidable harm persist?

- 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 operates as an effective safety management system; safety as a core purpose



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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

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At the Point of Care: 5 Moments of Medication Safety

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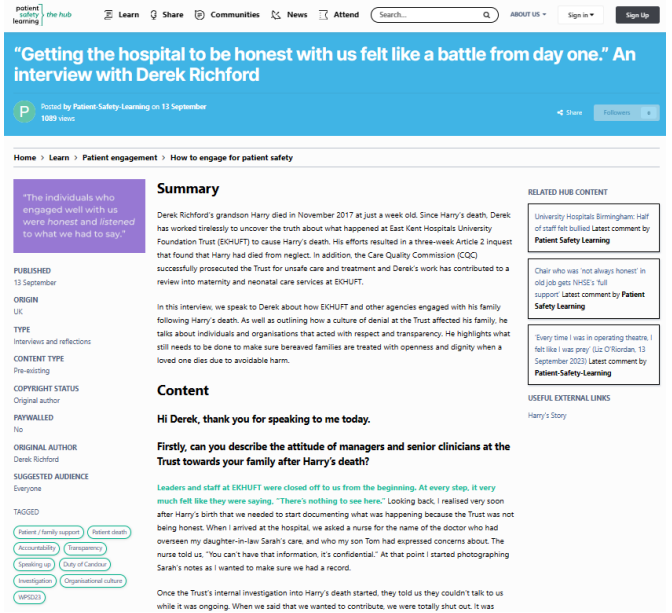
When things go wrong: Derek Richford

- 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.



Patient voices in a fragmented patient safety landscape

National improvement agencies and programmes

- NHS Horizons
- AQUA
- Getting it Right First Time (GIRFT)
- NHS Impact

Ombudsman

- Parliamentary and Health Service Ombudsman

Patient safety bodies

- Healthcare Safety Investigation Branch
- Patient Safety Commissioner for England
- National Guardian's Office

Government and Parliament

- Department of Health and Social Care
- Health and Social Care Select Committee

National coordinating groups

- National Quality Board
- National Patient Safety Committee

National NHS bodies

- NHS England National Patient Safety Team
- NHS Resolution

Standard setting bodies

- Medical Royal Colleges
- National Institute for Health and Care Excellence
- Professional Record Standards Body

Regional and local area bodies

- NHS England Regional Teams
- Integrated Care Systems
- AHSNs and patient safety collaboratives
- Healthwatch
- Coroners

Providers

- Acute Trusts
- Ambulance Trusts
- Mental Health Trusts
- Community Health Trusts
- Primary care organisations
- Primary care networks

System and professional regulators

- Care Quality Commission
- Medicines and Healthcare products Regulatory Agency
- Individual regulators of healthcare professionals
- Health and Safety Executive

Individuals

- Healthcare professionals
- Board members and non-executive directors
- Governors
- Medical Examiners
- Patient Safety Specialists
- Patient Safety Partners
- Freedom to Speak Up Guardians

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Source: Patient Safety Learning, The elephant in the room: Patient safety and Integrated Care Systems, 11 July 2023.

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

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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

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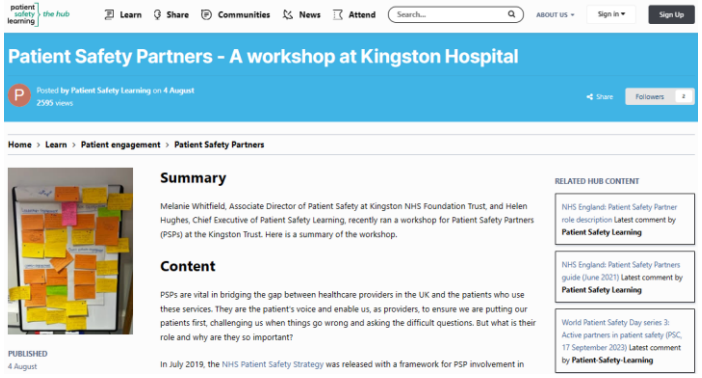
Patient Safety Partners

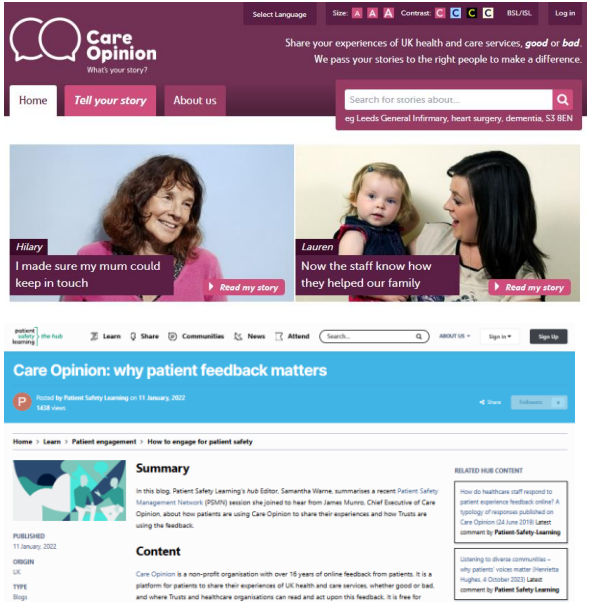
- Enabling patients to support and be involved in wider governance and leadership of safety activities, including:
  - Membership of safety and quality committees
  - Working with organisation boards
  - Involvement in staff patient safety training
  - Participation in investigation oversight groups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



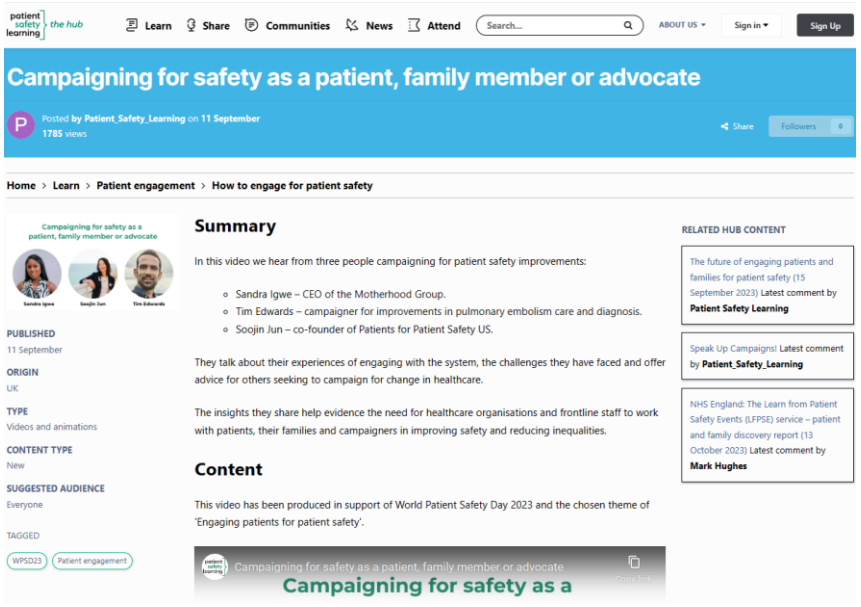
patient safety partners network

Patient engagement for Change and Improvement

Care Opinion



the hub (www.pslhub.org)



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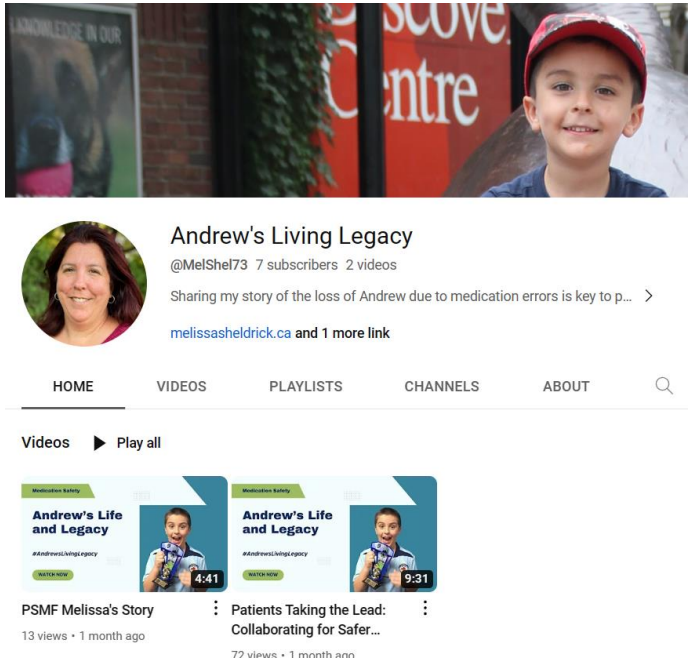
Success stories of patient engagement in patient safety

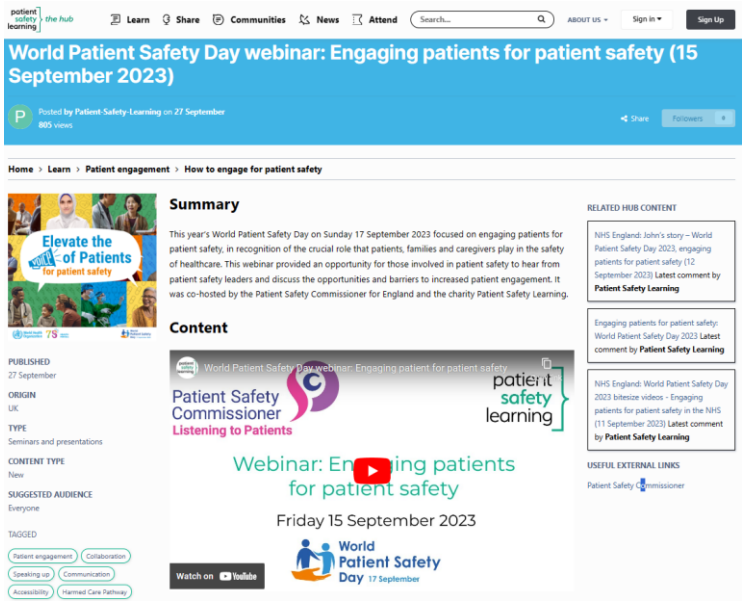


- Andrew's Life and Legacy
  - Supporting the implementation of continuous quality improvement in community pharmacies
  - Including anonymous error reporting
  - Legislative and policy changes across Canada
  - So others are not harmed
- Martha's rule – a right to a 2nd opinion

Source: https://melissasheldrick.ca/

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



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

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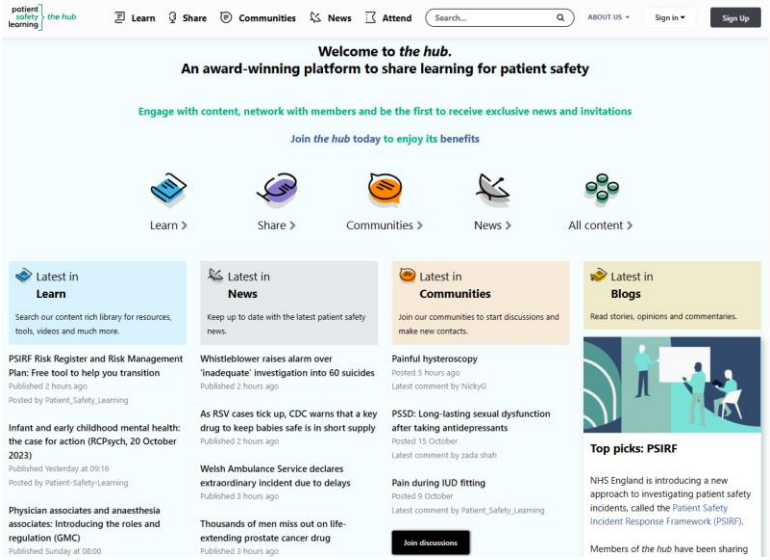
the hub at Patient Safety Learning

- 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



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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
  - LinkedIn: Patient Safety Learning

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