Safety at the heart of healthcare

Helen Hughes describes the steps being taken to address the widescale issue of avoidable harm

The World Health Organization estimates that avoidable harm in healthcare is one of the 10 leading causes of death and disability worldwide. The NHS states that in the UK there are around 11,000 avoidable deaths annually due to safety concerns. Suggestions are that this could have doubled during the COVID-19 pandemic.

Since the 1980s and 1990s there has been increased awareness and understanding of the importance of patient safety. However, despite a range of international and national initiatives aimed at reducing avoidable harm, this remains a persistent and widescale problem.

INDEPENDENT VOICE

Patient Safety Learning is a charity and independent voice for improving patient safety. We believe that to address the challenge of avoidable harm in healthcare we need to think and act differently, transforming our approach. We believe that patient safety is not just another priority – it is a core purpose of health and social care.

We are focused on two main areas of activity: policy influencing and campaigning; and patient safety through 'how to' resources, products and services.

Above: Patient safety is paramount in healthcare

Right: The Patient Safety Learning hub launched in 2019 and has seen its impact increase significantly

SIX FOUNDATIONS OF SAFE CARE

In our report, *A Blueprint for Action*, we outline what we believe is needed to address the underlying systemic causes of avoidable harm. Underpinned by analysis and evidence, we identify six foundations of safe care for patients along with practical actions:

1. Shared learning

Organisations should set and deliver goals for learning, report on progress and share their insights widely for action.

2. Leadership

We emphasise the importance of overarching leadership and governance for patient safety, including modelling behaviour that creates a just culture.

3. Professionalising patient safety

All staff should have the skills, knowledge, and support to deliver safe care, and recognise that organisational standards and accreditation for patient safety need to be developed and implemented.

> **“We believe that all health and social care organisations must have access to patient safety standards”**

These standards need to be used by regulators to inform their assessment of safe care.

4. Patient engagement
We must ensure that patients are valued and engaged in patient safety at the point of care if things go wrong, and in co-producing improvements in services.

5. Data and insight
Ensure better measurement and reporting of patient safety performance, both quantitative as well as qualitative – not just capturing data on error and avoidable harm, but proactively assessing risk.

6. Just culture
All organisations should publish goals and deliver programmes to eliminate blame and fear, introduce or deepen a just culture, and measure and report transparently on progress.

DEVELOPING STANDARDS

One of the key reasons that we struggle to reduce avoidable harm in healthcare is that we don’t have or apply standards for patient safety at a system and organisational level as we do for other safety issues, or in a way that other industries approach safety management systems.

We believe that all health and social care organisations must have access to comprehensive patient safety standards and that, by adopting and implementing standards, these organisations will be able to deliver safer care and embed a commitment to patient safety throughout their work. This would also enable patients, leaders, clinicians, the wider public and regulators to assess their progress and performance.

Since 2020 we have been developing and designing a set of unique patient safety standards and support tools that can help organisations not only establish clearly defined safety aims and goals, but also guide their implementation and demonstrate their achievement.

These standards are based on 20 years of research, as well as learning from inquiries, policy and good practice from healthcare, both in the UK and internationally. We have built on insight and learning from human factors and ergonomics widely applied in other safety-critical industries.

We have supplemented this with our own research, working in partnership with organisational patient safety specialists and practitioners to ensure that our standards are quality assured with ‘real world’ practicality. Our aim is that these will help to deliver enhanced, evidence-based safety outcomes and behaviours.

We are currently working with NHS organisations on how these standards and a self-assessment tool that we have developed can be implemented as an integral part of a broader programme of changes for managing patient safety. We will formally launch our Patient Safety Standards later this year.

Helen Hughes
Chief Executive of Patient Safety Learning

SHARED LEARNING

Another ‘how to’ resource we have developed to improve patient safety is the hub (pslhub.org), our free shared learning platform for patient safety. Designed by and for patient safety professionals, clinicians and patients, the hub offers a powerful combination of tools, resources, stories, ideas, case studies and good practice to anyone who wants to make care safer for patients. Its core features include:

- Learn – the knowledge repository area of the hub, moderated to ensure the content is consistently high quality
- Communities – a place to discuss patient safety concerns and how to address them
- News and Attend – updates on patient safety initiatives, current issues and upcoming events.

Since its launch in October 2019 the hub has had 791,000 page views and over 396,000 visits. It now has 2,600 members from 980 organisations across 74 countries.

There are several key areas of surgical safety where we have been building up resources on the hub and receiving contributions from members, including work to prevent surgical fires and surgical site infections, meet the challenge of the elective care waiting list and acknowledge the importance of preoperative and postoperative preparation and care.

We are also supporting the establishment of a National Safety Standards for Invasive Procedures network where leaders can meet, share insights and resources, and promote good practice.

We gather and monitor this resource’s impact on a continual basis and know that healthcare professionals use it to source proven good practice and apply it to their own organisations. Patient groups and communities of interest are using it to network and campaign with greater visibility and effectiveness. We are also seeing it being used by staff and patients as an informal source of research to collect insights and perspectives from the frontline of patient safety.

Join the hub today

We welcome the support of the Royal College of Surgeons of Edinburgh and look forward to its Members accessing our extensive range of resources for learning, contributing and sharing knowledge for safety.

Sign up for free at pslhub.org and join the growing number of healthcare professionals, patients, managers, regulators, researchers, policymakers and campaigners as we support the global online community of people who share the same vision as us – a world where patients are free from avoidable harm.

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