The future of patient safety

Shifting the focus from past harms

Helen Crisp
Background to the Health Foundation:

Our mission: *To improve quality of health and healthcare*

1983 – Private Patients’ Plan Medical Trust established
1998 – sale of PPP to commercial insurer endows charity with £540 million

- Focus: *medical research*

2003 – re-launched as The Health Foundation

- Focus: *Improving quality of care*
  - Patient safety
  - Person-centred care

2013 – New CEO – broader aims covering:

- *Improving quality of care*
- Health policy analysis
- Population health
What do we want?

**Better health and health care**

WHAT WE WANT

- to improve health service delivery
- to make health policymaking more effective
- a healthier UK population
How does the Health Foundation help to achieve this?

Across the three areas of focus we:
- test innovations and spread what works
- build skills and knowledge
- develop and share the evidence base
Focus on patient safety
How do we know care is safe?

We measure a lot, but...

- Are patients any safer than they were 10 years ago?

- Is your organisation safer than it was last year?

Available to download free from: www.health.org
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Different facets, different perspectives
- Harm, error, reliability, resilience, other indices?

Focus on how harmful our systems have been, not how safe our systems are
- Active safety management
Looking beyond ‘past harms’

Presentation based on work by:

- Charles Vincent
- Susan Burnett
- Jane Carthy

Commissioned by the Health Foundation

Available to download free from: www.health.org
Methods

- Literature review
- Interviews with senior staff in national organisations
- 11 case studies of healthcare organisations in the UK and USA
5 Questions:

1. Has patient care been safe in the past?

2. Are our clinical systems and processes reliable?

3. Is care safe today?

4. Will care be safe in the future?

5. Are we responding and improving?
A framework to consider safety

Past harm
Has patient care been safe in the past?

Integration and learning
Are we responding and improving?

Reliability
Are our clinical systems and processes reliable?

Anticipation & preparedness
Will care be safe in the future?

Sensitivity to operations
Is care safe today?
Huge amount of effort is spent here:

- Surgical complication rates
- Incidence of infection
- Violent incidents on mental health wards

All of these are important – data used for analysis and trend monitoring BUT:

Past performance is no guarantee of future performance

Past performance is no guarantee of future performance
Expanding our ideas about ‘harm’

View of ‘harm’ becomes more nuanced with a greater focus on safety to include:

- delayed or inadequate diagnosis
- failure to provide appropriate treatment
- over-treatment
- general harm
- psychological harm

No single measure can cover all these aspects
Reliability

Are our clinical systems and processes reliable?

Defined as ‘failure free operation over time’

Reliable systems function correctly under ‘expected’ conditions

Systems and processes in clinical care tend to be more unreliable than other industries
Research into reliability

Original research by Prof. Bryony Dean Franklin and others

7 Hospital trusts
6 Clinical systems:

• Availability of information
• Correct equipment available
• Systems for safe prescribing

Average failure rate 13% - 19%

Response of ‘work-arounds’
Improving reliability

Evaluation led by Prof Mary Dixon-Woods

Improvement programme supporting clinical teams to:

- Detect and assess system weaknesses
- Develop local solutions to these
- Proactive approach
- Use of safety cases
The challenge is to achieve heightened awareness of safety:
- All staff
- All the time
- Use systems information in real time
Approaches include:

- Safety walk-rounds
- Structured daily conversations; between staff, teams, managers
- Shift briefings and de-briefings e.g SBAR
Aim is to be smart **before** there is harm

- Identify and monitor risks across the clinical system
- Undertake ‘safety culture’ surveys
- Be aware of the indicators for possible increased risk:
  - Staff absence and sickness rates
  - ‘Daily irritations’
Involving patients

Another facet of ‘preparedness’

- Increase awareness of safety before people become a patients
- Work with wider community and user groups
- Involve patients as researchers and in monitoring
Integration and learning

Are we responding and improving?

Lots of information but how to interpret meaningfully?

Different levels have different needs: e.g. Clinical Unit : The Board

Not just reporting:
- analysis
- Learning
- Feedback
- and ACTION in response
Applying the framework

Testing in 6 health care organisations:

- Acute hospitals
- Mental health services
- Community health care

Positive response to simplicity and flexibility

Promotes discussion and questions – not imposing solutions

Different approaches for an organisation compared to clinical service or patient pathway
Feedback

“It’s helped us see where current safety work ‘fits’. Initiatives have worked in isolation - not always helpful”

“Discussions about safety have moved from being adversarial about past errors, to collaborative - looking to future”

“It’s so refreshing that there’s an ‘initiative’ that doesn’t mandate something new - we review what we need to do”

“It’s a sense check for safety systems to see how they align and where the gaps are”
Framework for policy on safety

Informed the Berwick Review of Patient Safety

Adopted by the Care Quality Commission (England) as the conceptual base for the safety domain of inspections
A revised version of the framework?
More than 5 ‘blobs’

- A starting point to think about how safety is regarded and managed in the organisation
- A tool to help to balance the different elements
- Think about what’s going to help your organisation to be and become safer
Next steps
Do we know \textbf{where} care is safe?

Next steps for patient safety research and implementation

\textbf{Care outside the hospital setting:}
- Primary care
- Care homes
- Self-care in the home
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