PRESS RELEASE

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Patient Safety Learning urges new approach by health and social care sector to stop thousands of avoidable deaths each year

Charity launches new online hub for vital sharing of knowledge and experience by health and social care providers and bodies, and patients and families, to transform services

(LONDON, UK, SEPTEMBER 23) - Patient Safety Learning today announced a campaign to end the thousands of avoidable deaths each year from unsafe patient care.

The charity is calling for a new approach throughout all areas of the health and social care system to ensure improvements in patient safety. This involves providers, commissioners, policy makers, regulators, patient groups, and individual patients and families.

Patient Safety Learning believes there needs to be a significant shift in thinking to prevent unsafe care, with a focus on actively learning from good practice through shared learning and experience, aside from investigations required after an incident.

Every year, says the charity, avoidable harm leads to the deaths of thousands of patients, with tens of thousands more enduring long-term suffering which costs the NHS billions of pounds.

Recent analysis has suggested that we may fail to save around 11,000 lives a year due to safety concerns[1], with the direct cost to the NHS of clinical negligence in 2017/18 of £2.2 billion[2].

Helen Hughes, chief executive of Patient Safety Learning and an expert in patient safety systems thinking and policy, said: “There has been a lot of good work done in the past 20 years but patient safety remains a persistent problem.

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[1] Hogan et al, in NHS Improvement (July 2019) *The NHS Patient Safety Strategy: Safer culture, safer systems, safer patients (p. 3)*

[2] NHS Resolution. *Annual Report and Accounts 2017/18.; 2018*

"There needs to be a transformation as to how patient safety is addressed across health and social care systems, so that there is much more focus on what approaches have worked well, not solely the required actions in response to unsafe care."

At the core of this new drive, is a unique *hub* designed as an online platform and community for anyone committed to improving safety - from patients and their families, through to clinicians, health professionals and health and social care organisations.

the hub will be a crucial online repository for sharing different experiences and perspectives of what has worked well, as well as case studies, research papers, blogs, investigation reports, policy guidance, and toolkits. It will provide a platform where people can ask questions, seek advice and share ideas to improve patient safety. Registration and use of *the hub* are free.

Patient Safety Learning has been focused on driving change and new thinking on patient safety since it was set up in 2018. Led by a Trustee Board that includes senior clinicians, health specialists and academics it believes strongly that the sharing of learning is the vital next step in the drive to reduce avoidable harm.

The charity's *hub,* currently in beta version, was designed with clinicians, patient safety experts and patients following research by Carl Macrae, professor of organisational behaviour and psychology at Nottingham University Business School and a renowned specialist on patient safety.

He highlighted that knowledge often remains trapped; it can be very hard for lessons and for learning to 'travel' between different organisations. This is despite the fact that sharing the lessons and findings from serious incident investigations is a requirement for NHS healthcare organisations.

Helen Hughes, who led patient safety initiatives at the World Health Organisation and a former director of the National Patient Safety Agency, added: "*the hub* is the first such online platform and community in the health and social system, providing a digital library and information exchange for everyone. Our approach is fundamental to sharing knowledge and insight on patient safety.

"We hope that by everyone accessing resources on patient safety and sharing their innovative solutions and quality improvements, this will bring about a stronger culture of sharing learning, leading to change."

Development of *the hub*, which will be formally launched at the charity's annual conference in London on 2 October 2019, is a key part of Patient Safety Learning's *A Blueprint for Action* which details the key actions needed for a patient-safe future.

Dr Ted Baker, Chief Inspector of Hospitals at the Care Quality Commission, a strong advocate of the charity's approach on patient safety, said: "The approach of Patient Safety

Learning and *A Blueprint for Actio*n is a significant contribution to the issue of patient safety. It lays out how everyone involved in healthcare, including patients, can work together to bring about the change in culture that is needed to make our healthcare as safe as it can be.

"*The hub* will be a valuable asset to patient safety, a new resource to sharing learning from what has effectively and positively worked within the health and social care system, as well as lessons learned from when things go wrong."

Mother-of-four Joanne Hughes lost her 20-month-old daughter Jasmine in 2011 after she became ill with acute disseminated encephalomyelitis, a neurological condition triggered by a virus. A succession of communication failures led to unnecessary delays, misdiagnoses, and a failure to carry out appropriate monitoring when providing treatment in the lead up to her daughter's death.

Joanne believes there needs to much more transparency across the health system and that *the hub* will be a strong benefit in sharing learning.

She said: "It makes perfect sense. If everyone gets on board it will spread learning a lot quicker and I am 100% behind it. What I find outrageous and disrespectful is that, as in my case, a child can die and a hospital unit may learn from the incident but the learning often stops there, and isn't shared with the entire trust or any other trusts."

To register on *the hub*, click here. To review the conference agenda and book a ticket for the conference click here.

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Note to editors:

Patient Safety Learning

Patient Safety Learning is a charity, which helps transform safety in health and social care, creating a world where patients are free from harm. We identify the critical factors that affect patient safety and analyse the systemic reasons they fail. We use what we learn to envision safer care. We recommend how to get there. Then we act to help make it happen.

For more information: www.patientsafetylearning.org

A Blueprint for Action

Underpinned by systemic analysis and evidence, "A Blueprint for Action" proposes detailed practical actions to address the foundations of safer care for patients.

These foundations are:

- Shared learning through organisations setting and delivering goals for learning from incidents
- Professionalising patient safety through new standards and accreditation
- Leadership for patient safety across the health and social care system
- Wider patient engagement on patient safety in investigations, service improvements, more support for patients involved in patient advocacy
- Data and insight through models for measurement, reporting and assessment of patient safety performance
- Health and social care organisations' development of programmes and publishing goals to eliminate blame and fear, and introduce or deepen a Just Culture