Imperial College London

The Imperative of a Global Movement to Improve the Safety of our Patients

Time to move to a cultural era in patient safety of values, ethics and leadership at every level

Professor Mike Durkin
Norwegian Association of Senior Doctors
Scandic Ishavshotellet Tromsø, Norway
April 28, 2023

INSTITUTE OF GLOBAL HEALTH INNOVATION

Queens Tower
Imperial College London

NHS
National Institute for
Health Research

NHS
National Institute for
Health Research

Mail Online

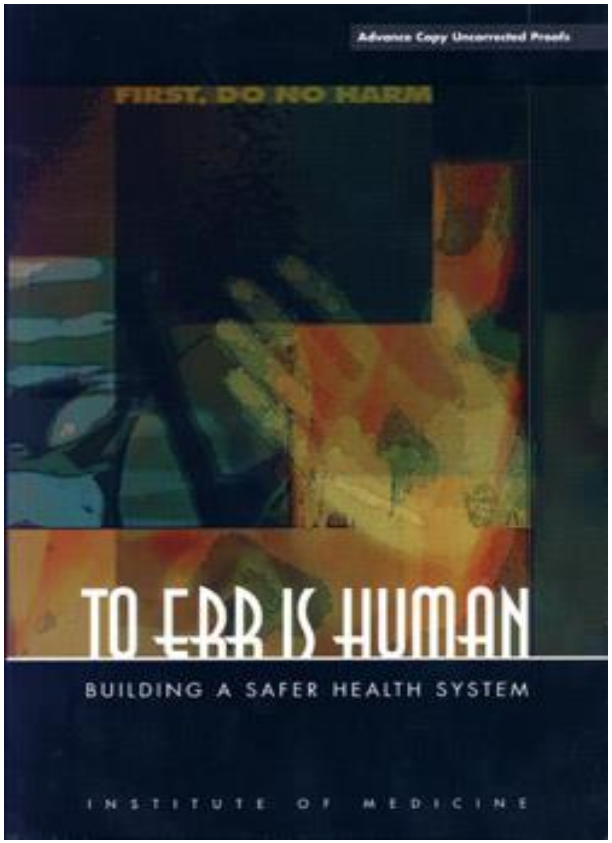
News

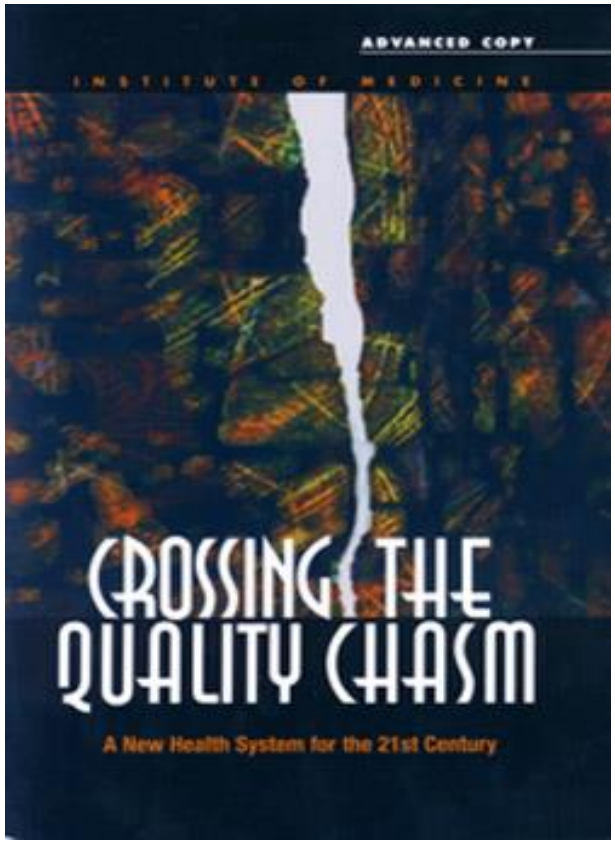
Out-of-hours NHS services failed three-year-old boy who died after suffering flu and a chest infection by not sending him to A&E

- Sam Morrish died at Torbay Hospital in South Devon in December 2010
- His parents took him to see health professionals four times in 36 hours
- Devastated family determined to find out why their son was allowed to die
- Scott and Susanna Morrish say they have been let down by the NHS
- Report by Health Service Ombudsman expected to be published this week

By VANESSA ALLEN FOR THE DAILY MAIL

PUBLISHED: 17:45, 22 June 2014 | **UPDATED:** 18:25, 26 June 2014





- **Quality** defines six aims:
  - safe,
  - effective,
  - patient-centered,
  - timely,
  - efficient and
  - equitable

Imperial College London

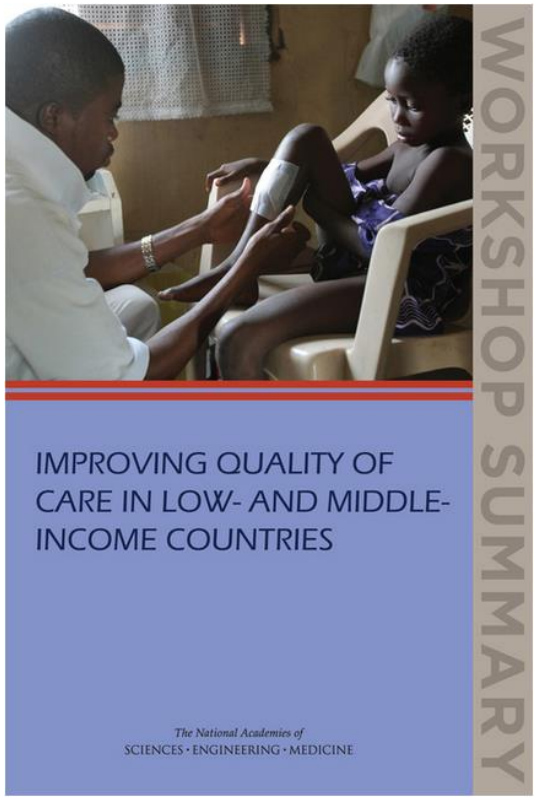
The UK Response

Imperial College London

Twenty Years On: Now Recognised as a Global Challenge

Imperial College London

Quality of Care in Low & Middle Income Countries

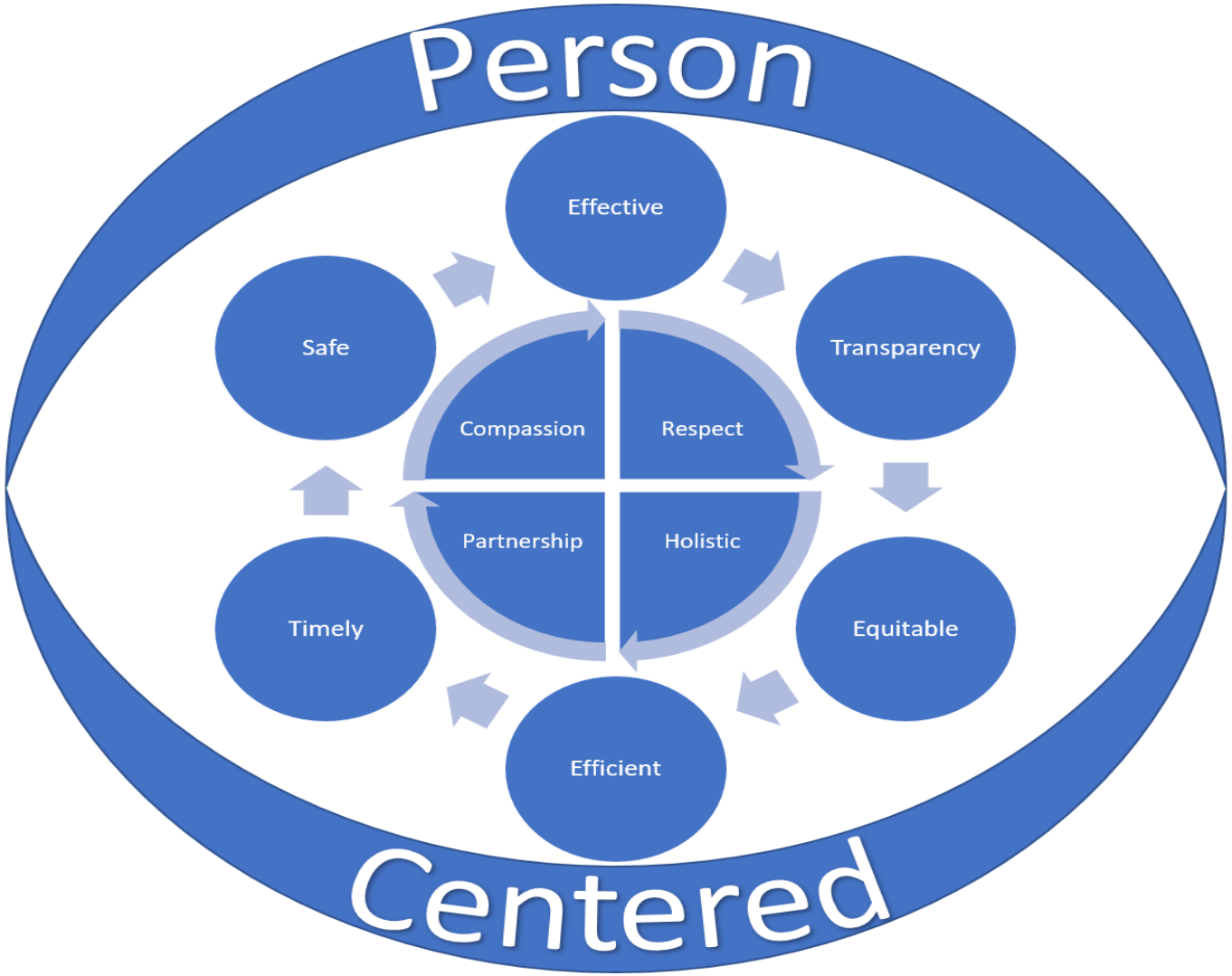


- The probability of a patient receiving the correct diagnosis is, depending on other factors, in the range of 30 to 50 percent (Jishnu Das)
- The probability of a patient receiving non-harmful treatment found a likelihood of about 45 percent (Jishnu Das)

NATIONAL ACADEMY OF MEDICINE

INSTITUTE OF GLOBAL HEALTH INNOVATION

ISQua's Values and Principles of Person-Centred Care (2015)



NHS
National Institute for Health Research

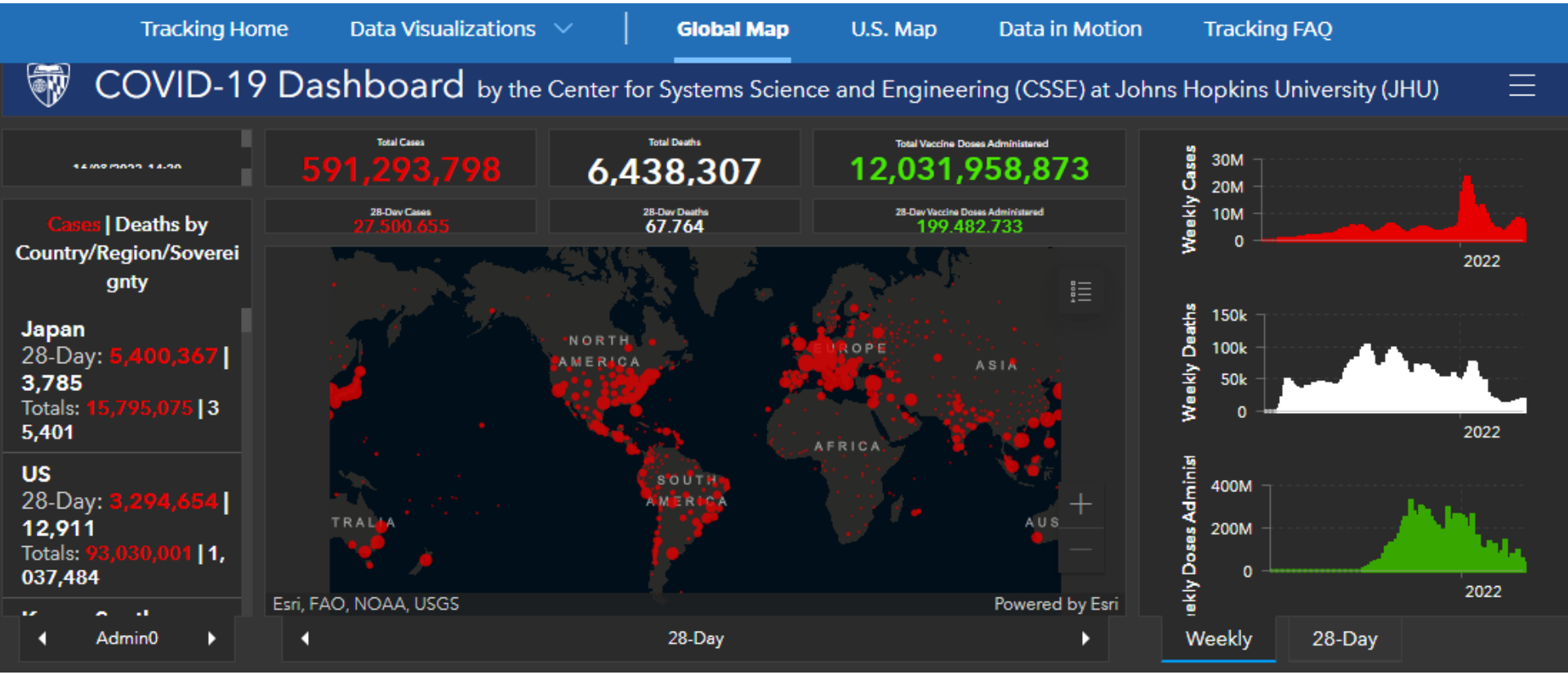
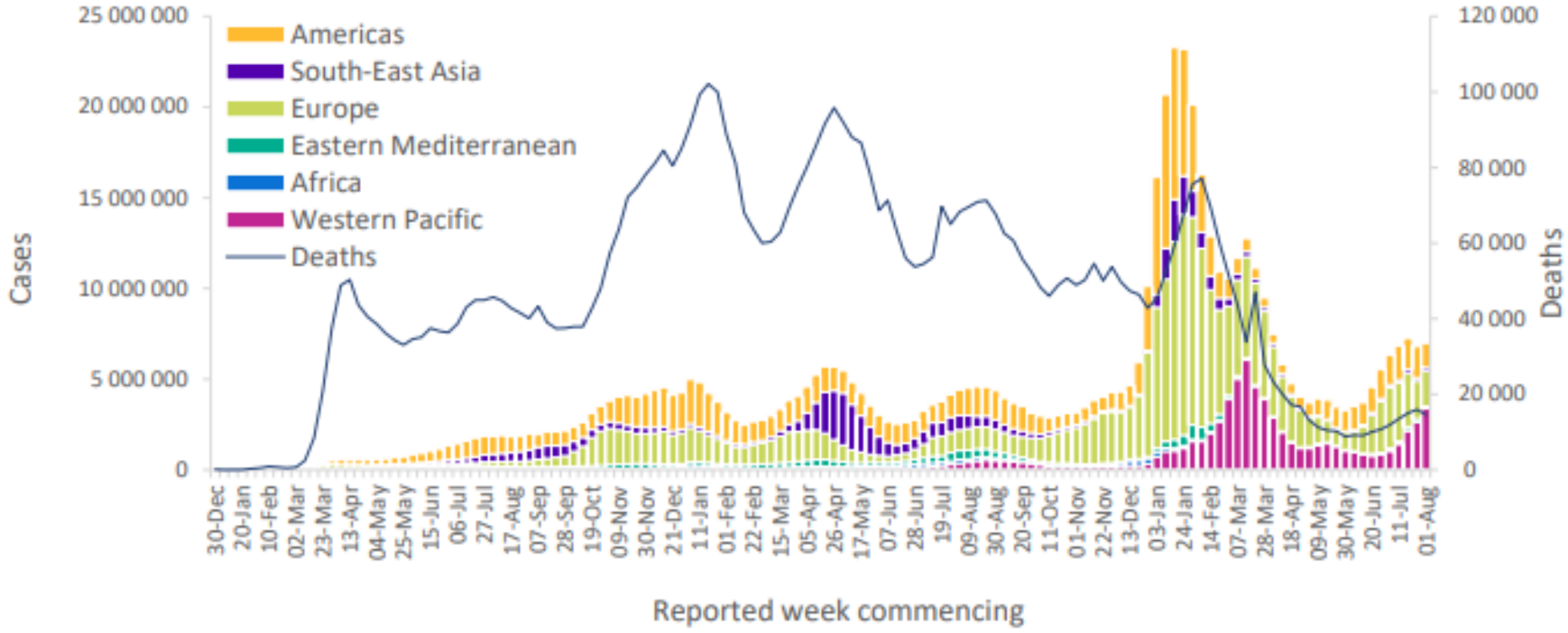


Figure 1. COVID-19 cases reported weekly by WHO Region, and global deaths, as of 7 August 2022**



"…the aim of leadership is not merely to find and record failures of men, but to remove the causes of failure: to help people to do a better job with less effort."

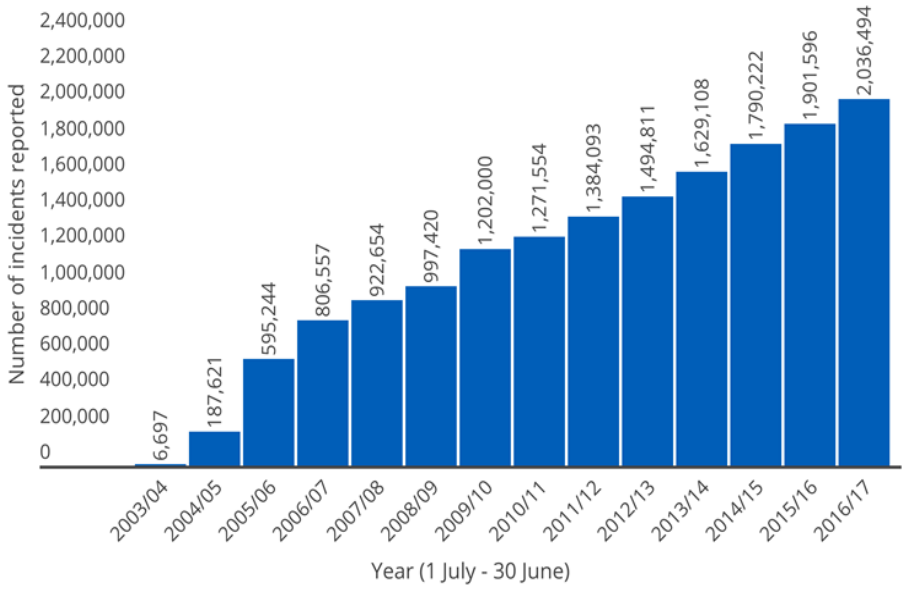
"In God we trust, all others bring data."

Dr W. Edwards Deming

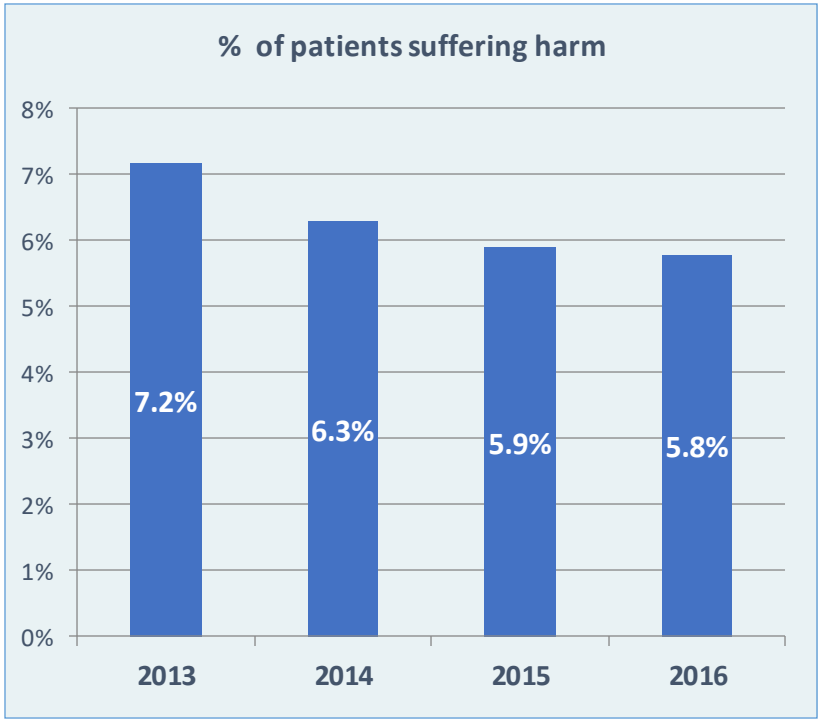
Our Cultural Shift to Increase the Reporting of Error and Learning to Reduce Harm

National Institute for Health Research

Total patient safety incidents reported to NRLS 1 July to 30 June each year since October 2003 launch (all geographical locations)



An estimated 86,000 fewer patients have suffered harmed due to falling harm rates from 7.2% of patients in 2013 to 5.8% in 2016.



Imperial College Healthcare NHS Trust

How our system works

Incident identified

- an event or circumstance that could have resulted, or did result, in unnecessary damage, loss or harm such as physical or mental injury to a patient, staff, visitors, or members of the public (NHS England, 2015).

Reported on Datix

- This includes the mandatory data fields required by the National Reporting and Learning Service (NRLS) and additional fields required by the Trust
- Includes **Level of Harm** and that the statutory **Duty of Candour** has been completed

Quality Assured

- Incident (including level of harm) reviewed at directorate/divisional level
- Any moderate harm or above incidents are reviewed at a weekly panel chaired by the AMD for Safety – declared as **serious incidents** (including **never events**)

Investigated

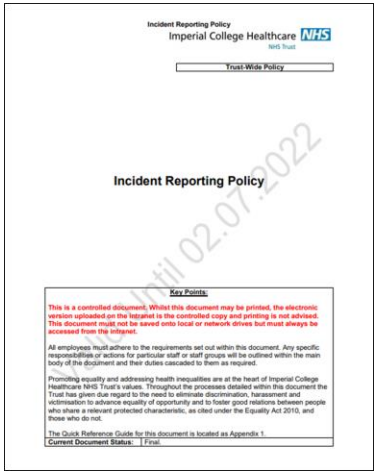
- Near misses and no harm/low harm incidents investigated and closed locally, with local actions and learning documented
- Moderate harm and above incidents investigated in accordance with the NHS Serious Incident Framework

Reported

- Any additional mandatory reporting completed
- For serious incidents, final report sent to the Clinical Commissioning Group (CCG) for final approval

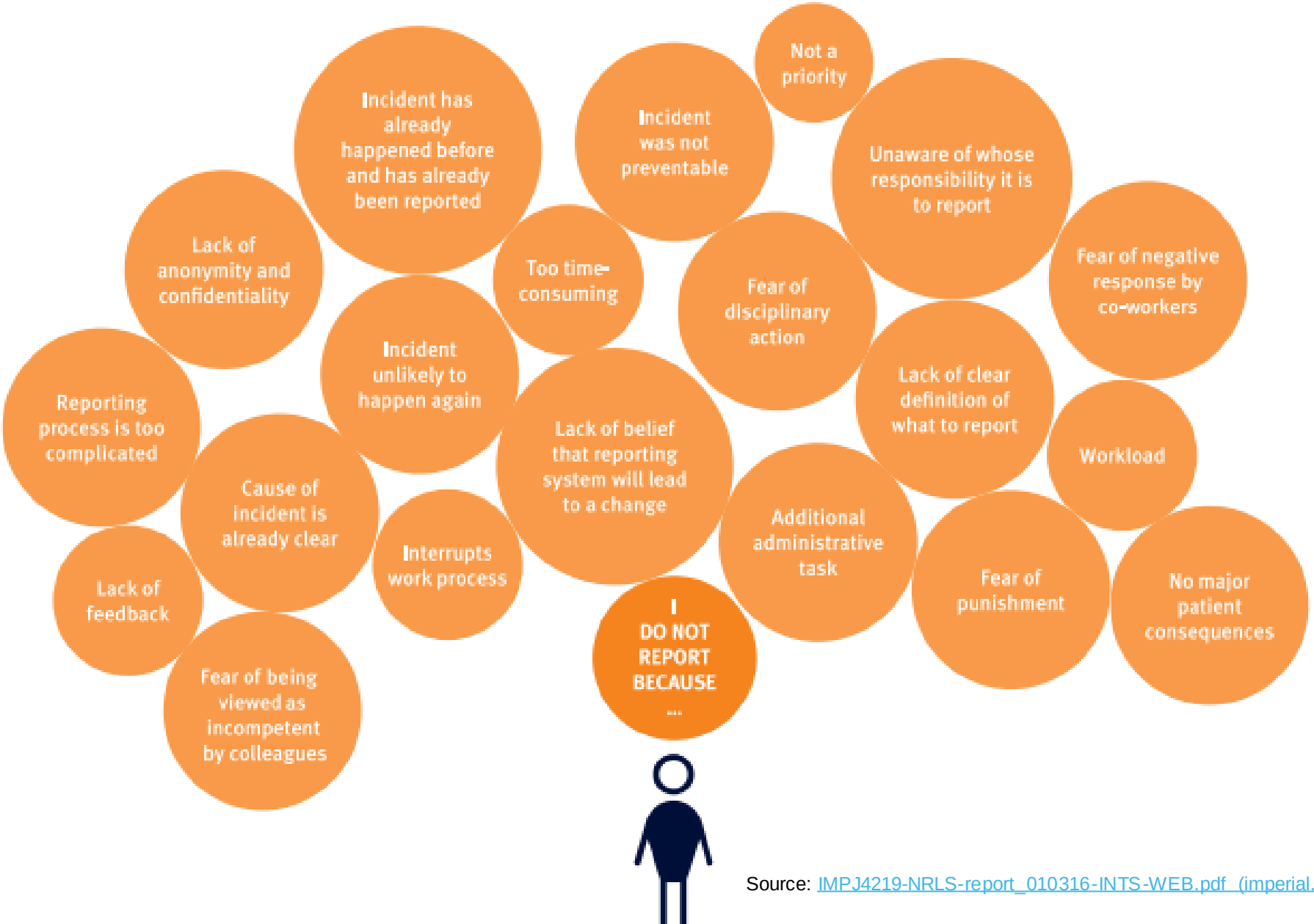
Closed

- Closed after actions and learning completed
- Regular upload of incident reporting data to the NRLS


Incident Reporting Policy
Imperial College Healthcare NHS Trust
Trust-Wide Policy
Incident Reporting Policy
Until 02.07.2022
Key Points:
This is a controlled document. Whilst this document may be printed, the electronic version uploaded on the Intranet is the controlled copy and printing is not advised. This document must not be saved onto local or network drives but must always be accessed from the intranet.
All employees must adhere to the requirements set out within this document. Any specific responsibilities or actions for particular staff or staff groups will be outlined within the main body of the document and their duties cascaded to them as required.
Promoting equality and addressing health inequalities are at the heart of Imperial College Healthcare NHS Trust's values. Throughout the processes detailed within this document the Trust has given due regard to the need to eliminate discrimination, harassment and victimisation to advance equality of opportunity and to foster good relations between people who share a relevant protected characteristic, as cited under the Equality Act 2010, and those who do not.
The Quick Reference Guide for this document is located as Appendix 1.
Current Document Status: Final

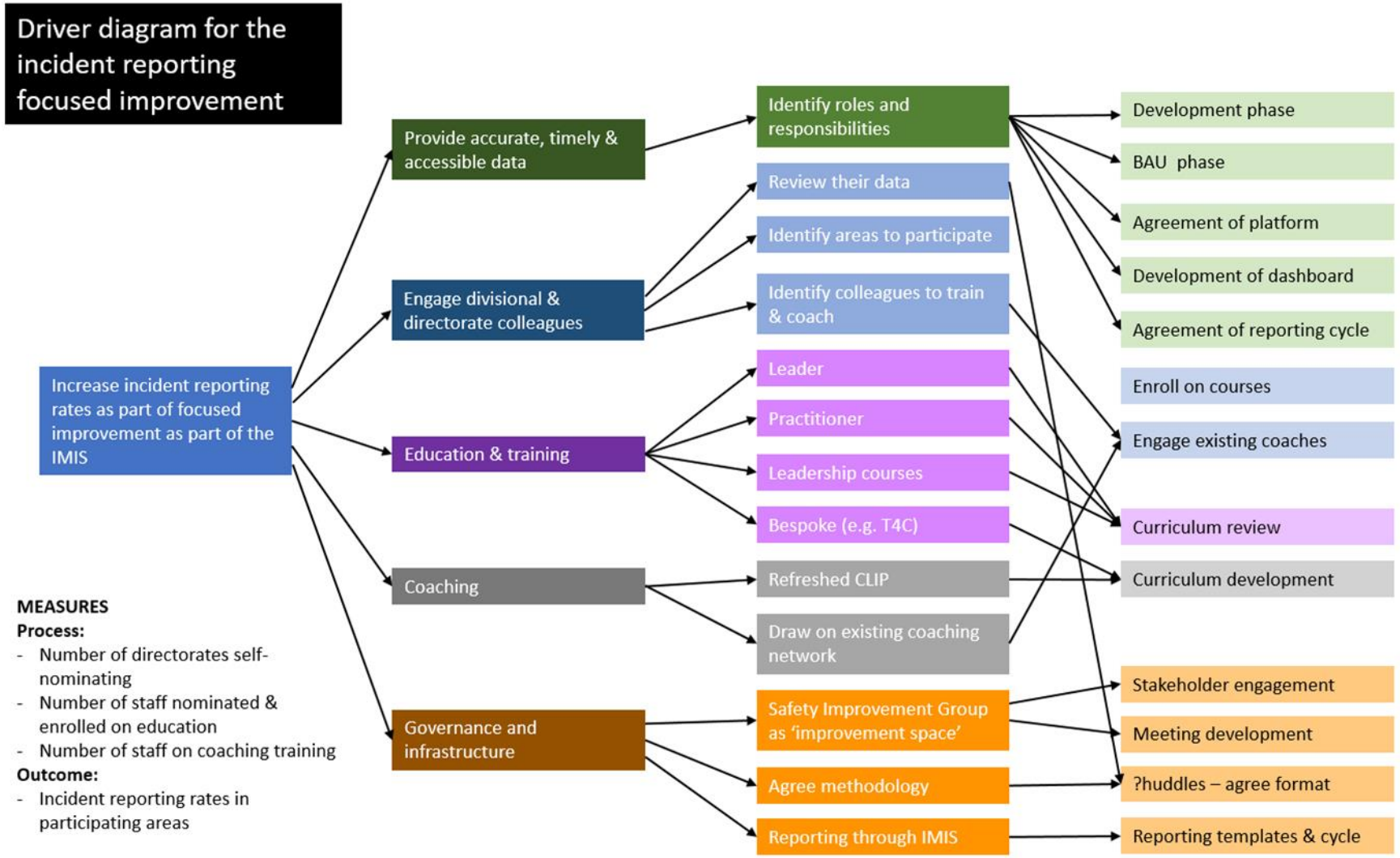
Some of the barriers to incident reporting

Imperial College Healthcare NHS Trust



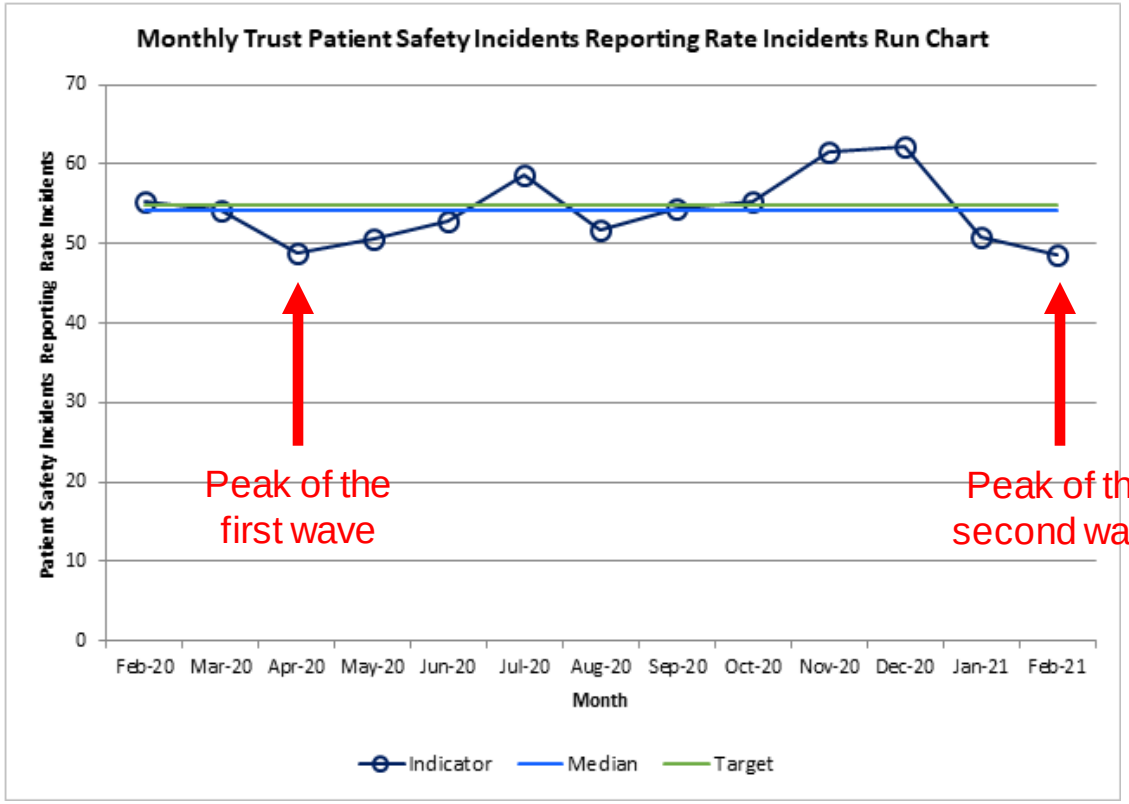
Source: IMPJ4219-NRLS-report_010316-INTS-WEB.pdf (imperial.ac.uk)

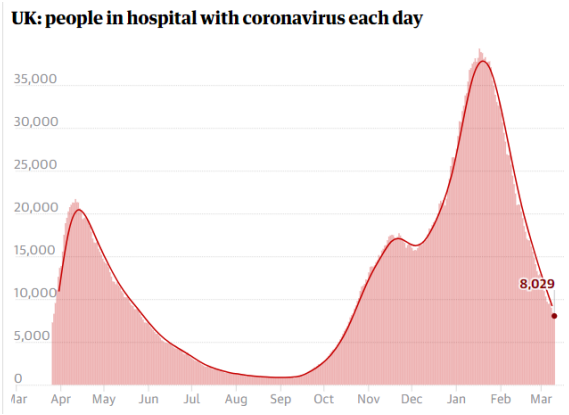
Some of the barriers to incident reporting



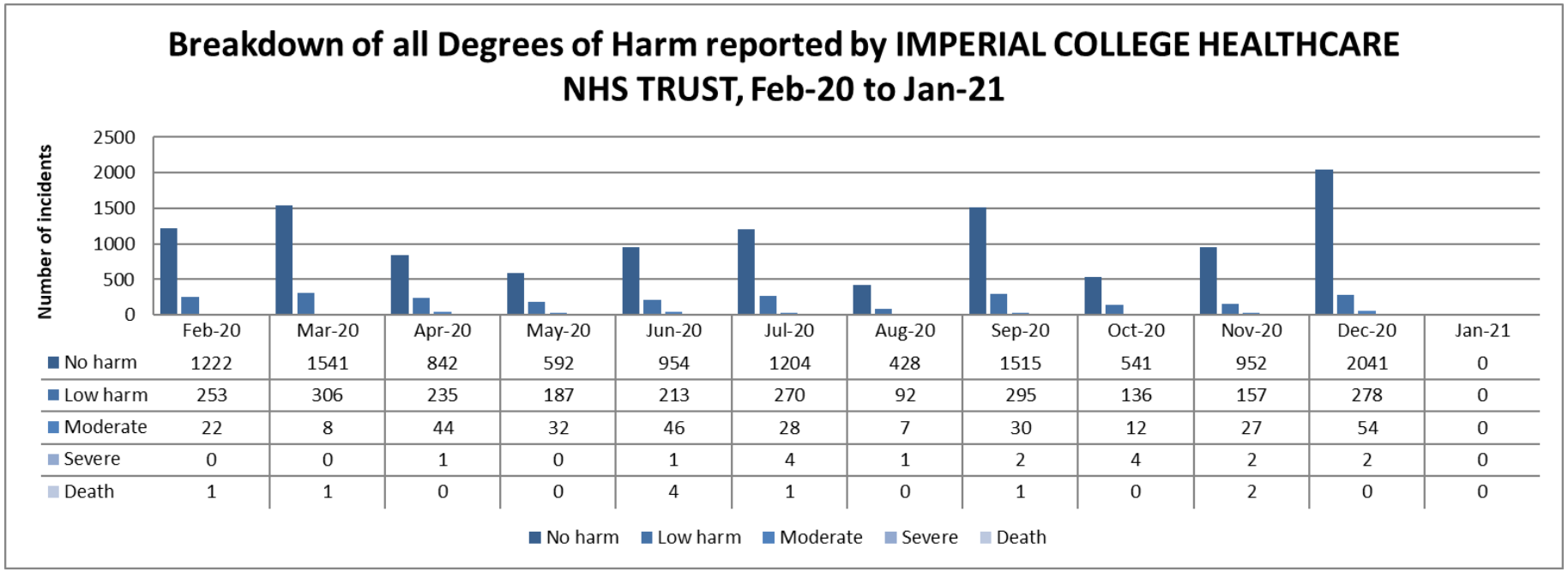
What do we report?

- Incident reporting rates are calculated per 1,000 bed days on a national level by the NRLS to ensure that they are comparable across different trusts.





What do we report?



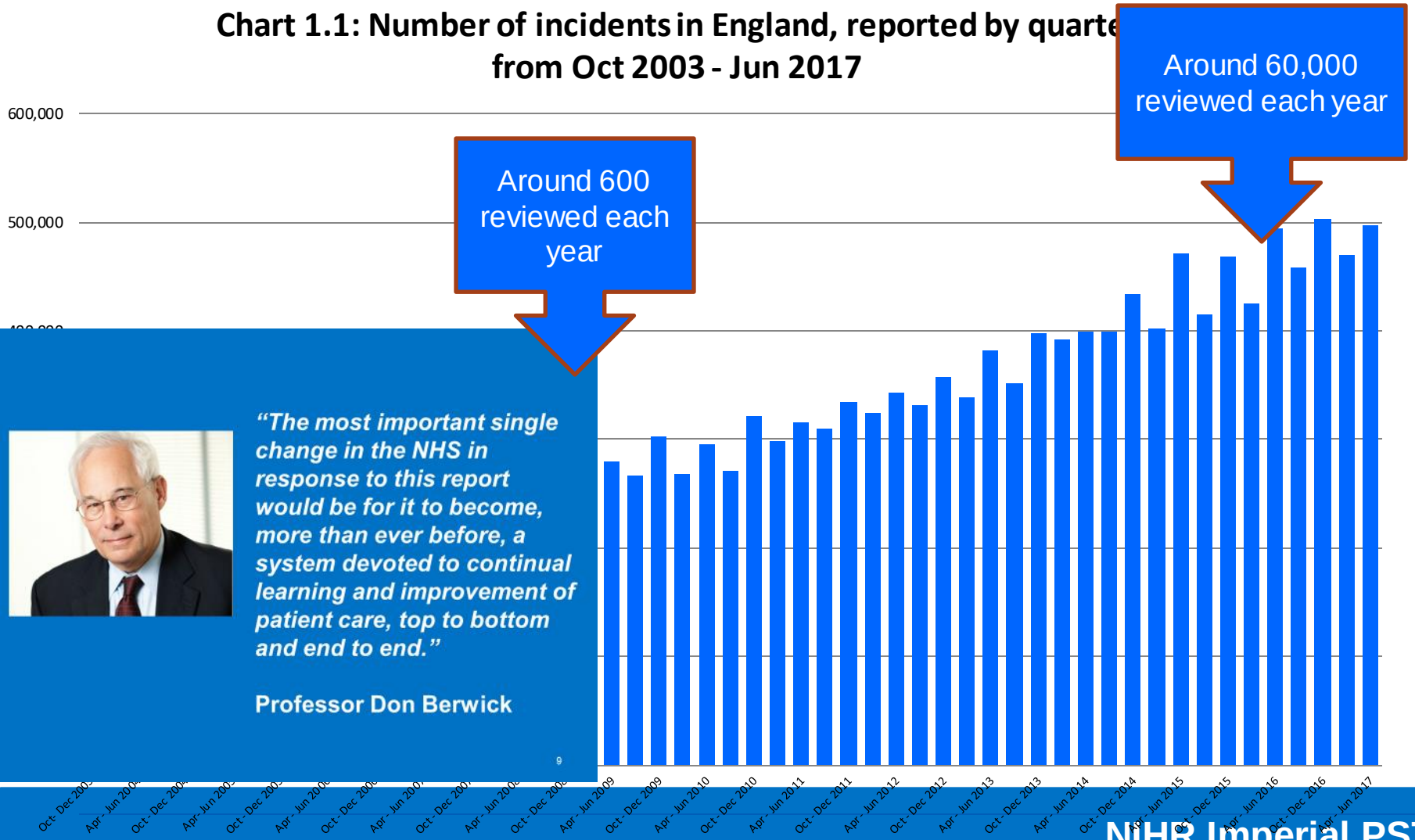
	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21
No harm	1222	1541	842	592	954	1204	428	1515	541	952	2041	0
Low harm	253	306	235	187	213	270	92	295	136	157	278	0
Moderate	22	8	44	32	46	28	7	30	12	27	54	0
Severe	0	0	1	0	1	4	1	2	4	2	2	0
Death	1	1	0	0	4	1	0	1	0	2	0	0

- Ratio of moderate or above: no/low harm & near miss has changed during the pandemic
- Change in the type of incident being reported (increase in pressure ulcers, failure to recognise the deteriorating patient, lack of beds, staffing incidents and hospital onset COVID-19 infections (HOCI))

Imperial College London

Learning not counting

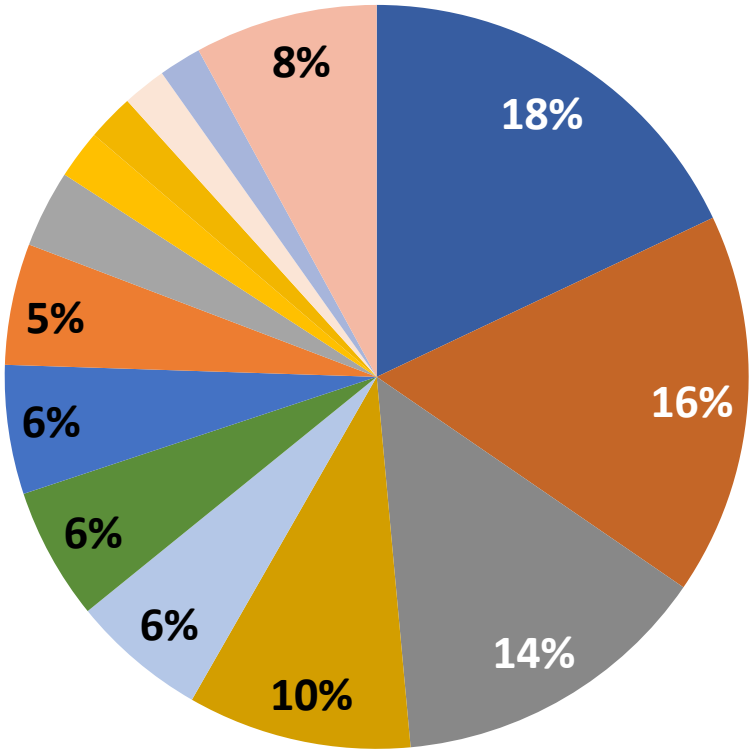
Chart 1.1: Number of incidents in England, reported by quarte
from Oct 2003 - Jun 2017



"The most important single change in the NHS in response to this report would be for it to become, more than ever before, a system devoted to continual learning and improvement of patient care, top to bottom and end to end."

Professor Don Berwick

Most death and severe harm sadly fall into known themes; the 'giants' of patient safety

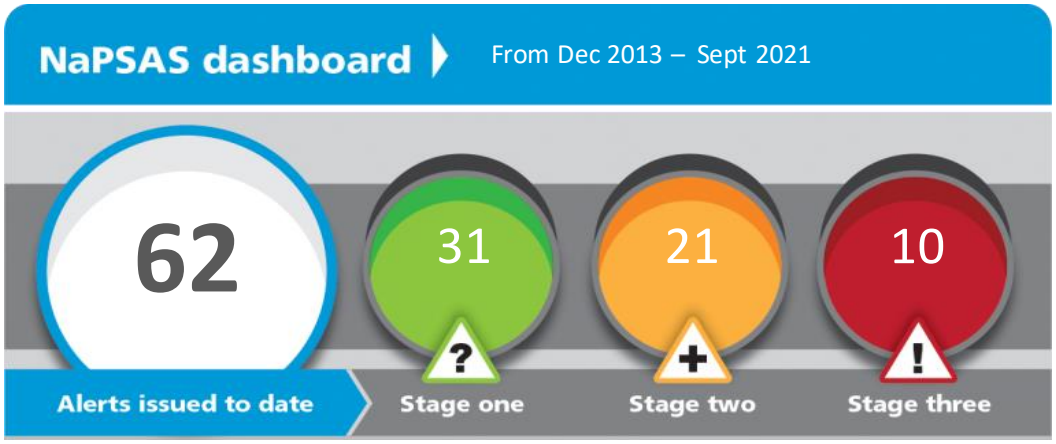


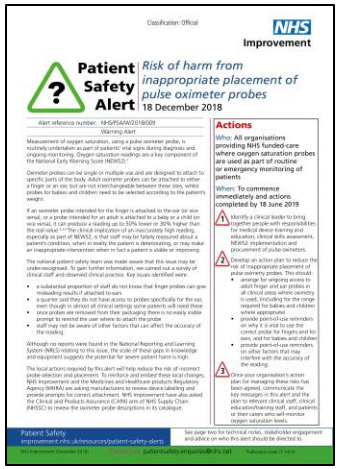
All care settings: death and severe harm themes reported to NRLS for one recent year after clinical review

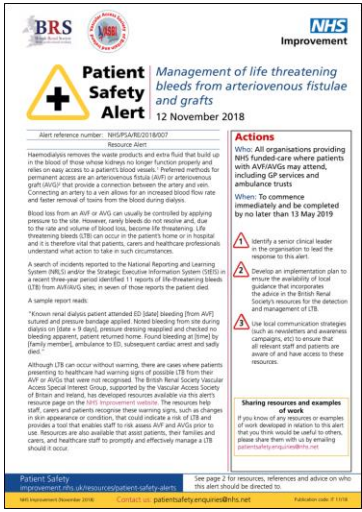
Imperial College London Institute of Global Health Innovation

World Patient Safety Day 17 September 2019

UK national patient safety alerting system







The role of National Patient Safety Alerting Committee (NaPSAC)

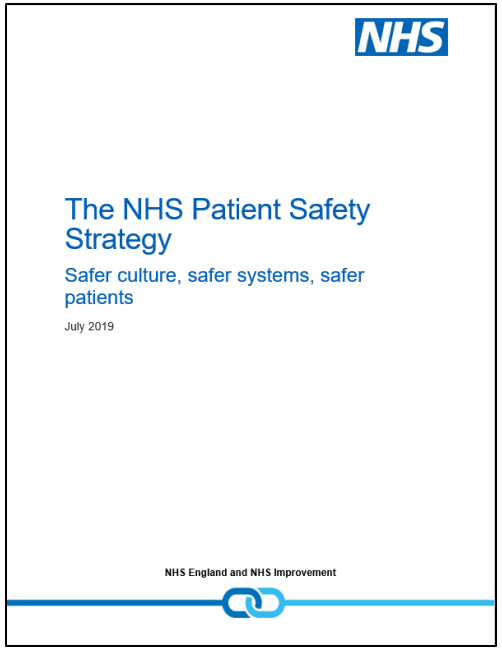
- Developing common standards and thresholds for National Patient Safety Alerts.
- Developing a single recognisable consistent format for National Patient Safety Alerts.
- Overseeing the development of a process to ensure all alert issuers reach these common standards and thresholds.

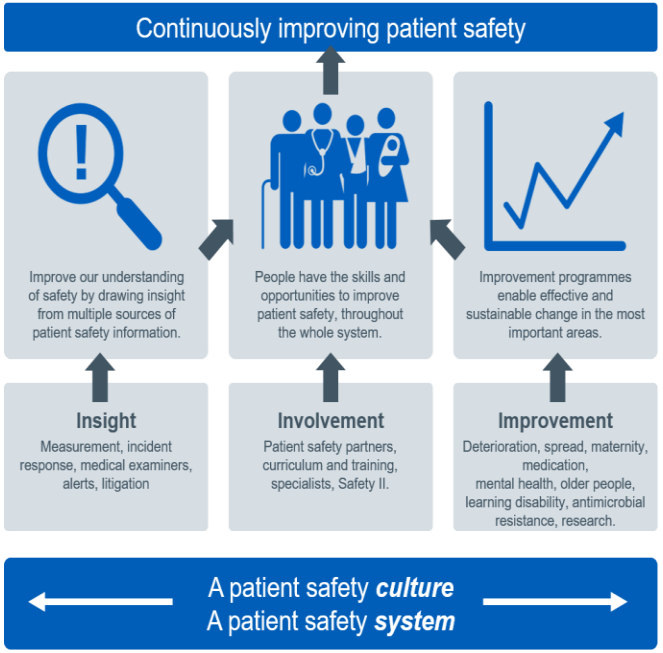
Collaborative – core clinical priorities

Imperial College Healthcare NHS Trust

Topic area	Patient Safety Topic							
The 'essentials'	Leadership				Measurement			
NHS Outcomes Framework improvement areas	Falls	Venus Thromboembolism	Healthcare Associated Infections		Pressure Ulcers		Maternity	
Other major sources of death and severe harm	Nutrition and Hydration	Handover and Discharge	Missed and Delayed Diagnosis	Medical Device Error	Acute Kidney Injury	Medication Errors	Sepsis	Avoidable Deterioration of Adults and Children
Vulnerable groups for whom improving safety is a priority	People with Mental Health needs	People with Learning Disabilities	Children	Offenders	Acutely Ill Older People		Transition between paediatric and adult care	

The NHS Patient Safety Strategy



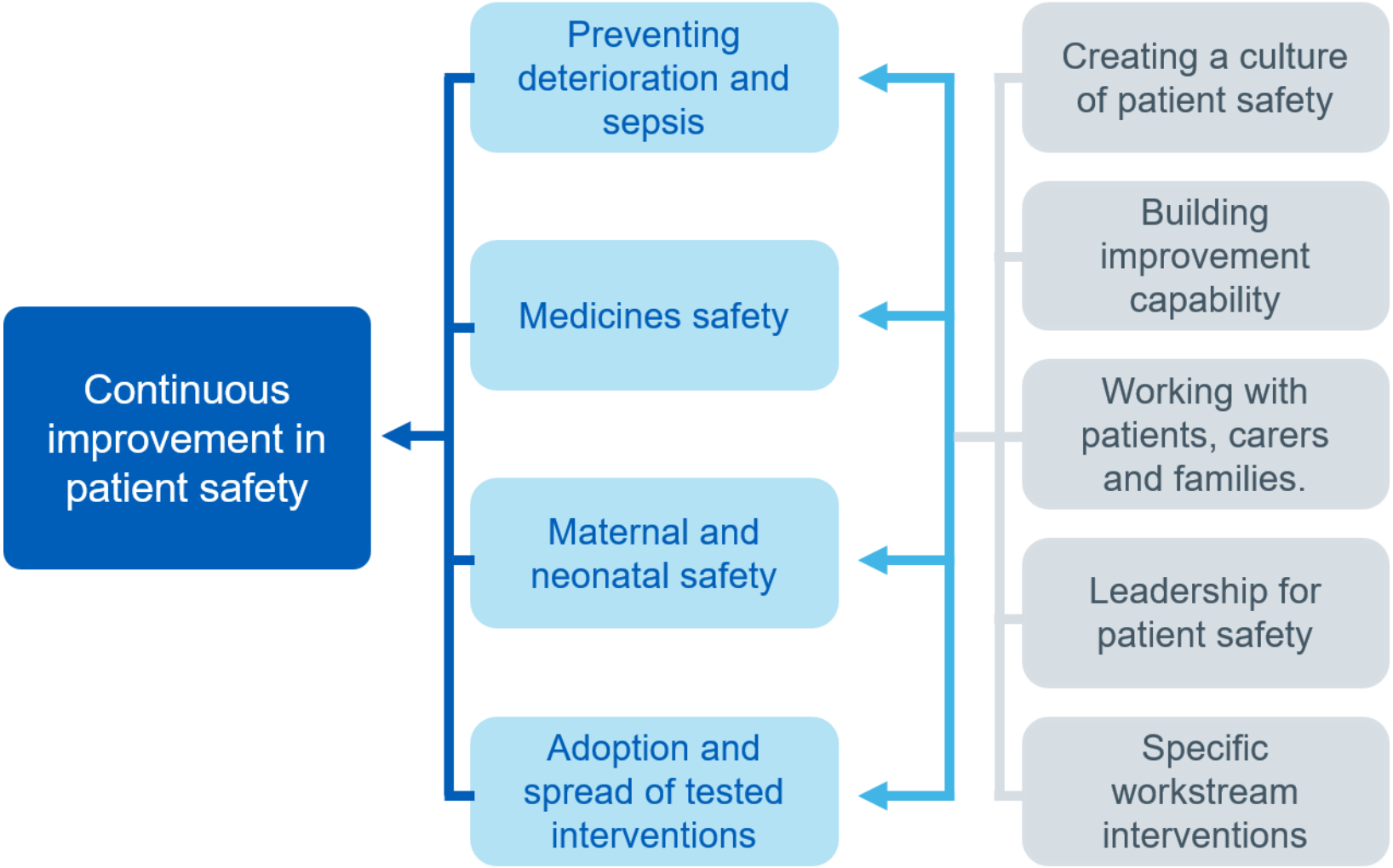


Safer culture, Safer systems, Safer patients

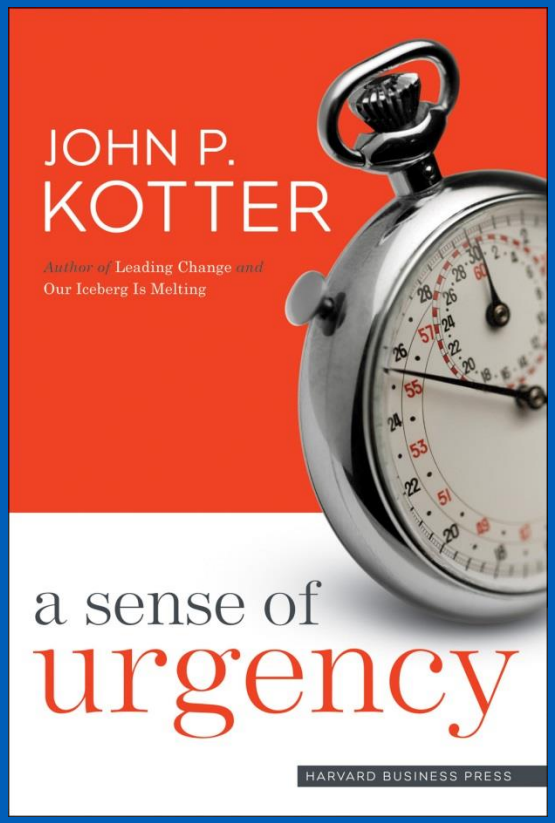
Imperial College London Institute of Global Health Innovation

World Patient Safety Day 17 September 2019

The National Patient Safety Improvement Programme



Urgency as a driver for change



"When people have a true sense of urgency, they think that action on critical issues is needed now, not eventually, not when it fits easily into a schedule. Now means making real progress every single day."

John Kotter

Creating urgency through transparency

National Institute for Health Research

Our work: Consultant outcomes

- Successful publication of surgeon level data from national clinical audits
- Across 12 specialties
- Helping the NHS drive up quality of care

Transparency means accepting risk to reputations

NHS
National Institute for Health Research

BBC | Sign in | News | Sport | Weather | iPlayer | TV | Radio

NEWS

Home | UK | World | Business | Election 2015 | Tech | Science | Health | Education | Ent

Health

A&E in England misses target for whole of winter

By Nick Triggle
Health correspondent

13 March 2015 | Health

The NHS in England has missed its A&E waiting time target for every week of winter, figures show.

theguardian
Winner of the Pulitzer prize

NHS hospital waiting time figures worst in seven years

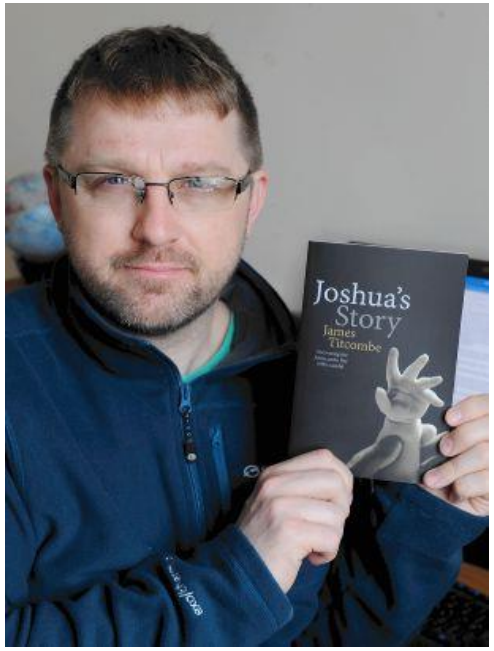
Almost 40,000 admitted patients not starting consultant-led treatment within 18 weeks of referral

The median waiting time to begin treatment reached a record 10 weeks in February. Photograph: Christopher Furlong/Getty Images

The number and proportion of NHS hospital patients in England waiting more than 18 weeks to begin treatment have risen to their highest levels in almost seven years, official statistics show.

“When you feel like running away from the patient, run toward the patient.”

Paulina Kernberg


Joshua's
Story
James Titcombe


NEXT
WHY HAS IT TAKEN SO LONG
400
DEATHS
ELLEN LINSTEAD
© PA

Imperial College London

Whistleblowing

The Telegraph

Meet the NHS whistle-blowers who exposed the truth

As Sir Robert Francis prepares to publish the first independent review of the treatment of whistle-blowers in the NHS, we look at some of those whose disturbing experiences led to the review:

213 378 0 30 621 Email

NHS whistleblowers

Health

NHS 'to get whistleblower guardians'

By Nick Triggle
Health correspondent, BBC News

11 February 2015 | Health

NHS trusts will have to appoint a guardian to help whistleblowers in England, ministers have confirmed.

The measure was called for by Sir Robert Francis after he warned staff too often faced "bullying and being isolated" when they tried to speak out.

Sir Robert, who led the public inquiry into the Stafford Hospital scandal, also said a new national officer should be appointed to help the guardians.

The government immediately accepted all his recommendations.

Health Secretary Jeremy Hunt said: "If we don't get the culture right we will never deliver the ambitions we have for the NHS."

Imperial College London

The Genesis of HSIB: The Public, Parliament and Practitioners developing Policy

Learning from failure: the need for independent safety investigation in healthcare"

Healthcare Safety Investigation Branch - EAG Recommendations

NHS Improvement

INDEPENDENCE, ENGAGEMENT AND LEARNING

1. Must be independent in structure and operation
2. Investigations must be to understand causes of harm, to support improvement, not to apportion blame
3. Patients, families and staff must be active, supported participants

SYSTEM-WIDE INVESTIGATION AND IMPROVEMENT

4. Must be empowered to investigate safety incidents anywhere across the entire healthcare system
5. Investigations must be led by experts in safety investigation and HSIB should provide leadership to the whole system on investigation
6. Investigation reports must explain causes of incidents and make recommendations
7. Reports must be public documents and recipients must publish responses

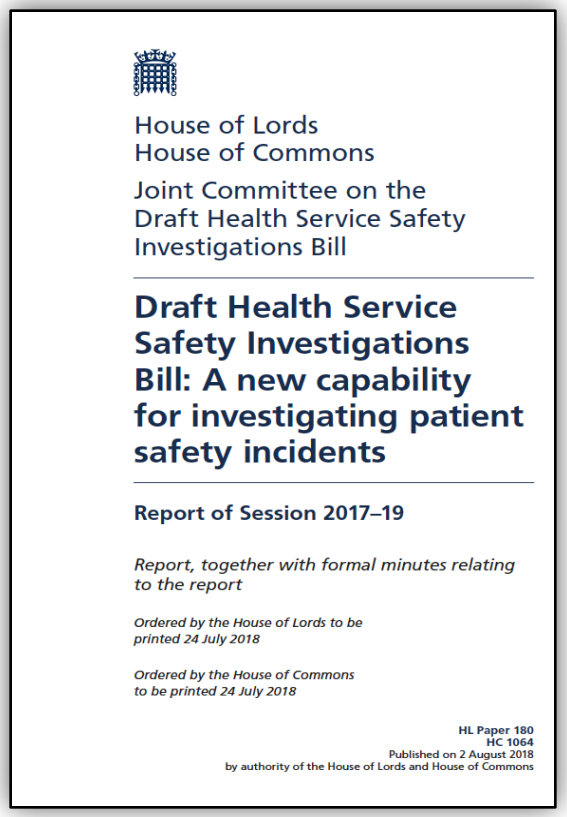
JUST CULTURE: TRUST, HONESTY AND FAIRNESS

8. Must promote creation of a 'just' safety culture
9. Must provide families and patients with all relevant information from an investigation about their care while protecting all information from use by other bodies or for other purposes
10. Information must be provided to investigators honestly and openly. Where evidence shows wrongdoing, negligence or unlawful activity the relevant body must be informed.

FURTHER ACTIONS REQUIRED ACROSS THE HEALTHCARE SYSTEM

11. Recommend a 'Just Culture' Task Force be established to make further recommendations about moving healthcare to a just culture
12. Recommend a programme of capacity building and improvement of safety investigation
13. Recommend a process to provide truth, justice and reconciliation in relation to unresolved cases

Imperial College London



House of Lords
House of Commons

Joint Committee on the Draft Health Service Safety Investigations Bill

Draft Health Service Safety Investigations Bill: A new capability for investigating patient safety incidents

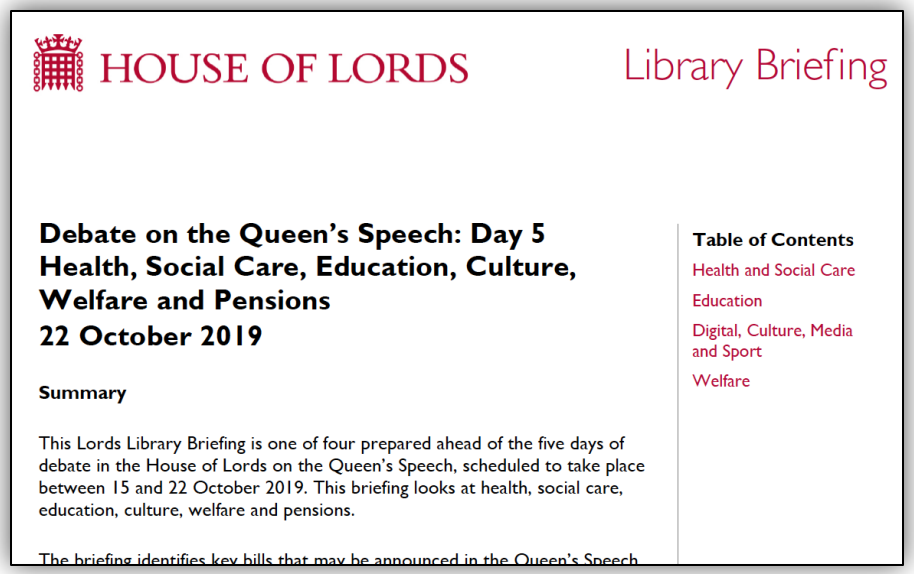
Report of Session 2017–19

Report, together with formal minutes relating to the report

Ordered by the House of Lords to be printed 24 July 2018

Ordered by the House of Commons to be printed 24 July 2018

HL Paper 180
HC 1064
Published on 2 August 2018
by authority of the House of Lords and House of Commons



HOUSE OF LORDS Library Briefing

Debate on the Queen's Speech: Day 5 Health, Social Care, Education, Culture, Welfare and Pensions 22 October 2019

Summary

This Lords Library Briefing is one of four prepared ahead of the five days of debate in the House of Lords on the Queen's Speech, scheduled to take place between 15 and 22 October 2019. This briefing looks at health, social care, education, culture, welfare and pensions.

The briefing identifies key bills that may be announced in the Queen's Speech

Table of Contents

HOUSE OF LORDS Library Briefing

Health Service Safety Investigations Bill [HL] HL Bill 4 of 2019–20

On 29 October 2019, the second reading of the Health Service Safety Investigations Bill [HL] is scheduled to take place in the House of Lords.

Summary

The factsheet accompanying the bill states its main objectives are to:

- establish the Health Service Safety Investigations Body (HSSIB) as a new independent arm's-length body with powers to conduct investigations into patient safety incidents that occur during the provision of NHS-funded services;

INSTITUTE OF GLOBAL HEALTH INNOVATION

“Every hospital should follow every patient it treats long enough to determine whether the treatment has been successful, and then to inquire ‘if not, why not’ with a view to preventing similar failures in the future.”

Ernest Amory Codman - 1914

Learning from Deaths

National Institute for Health Research

"Every hospital should follow every patient it treats long enough to determine whether the treatment has been successful, and then to inquire 'if not, why not' with a view to preventing similar failures in the future." *Ernest Amory Codman 1914*

- A new consistent NHS-wide case note review methodology has been developed for trusts own use.
- Training in this new methodology has started
- Trust boards will be expected to analyse the results of their own case note reviews to guide improvement
- Also linked to wider system response to CQC review

Original research

Preventable deaths due to problems in care in English acute hospitals: a retrospective case record review study

Helen Hogan,[1] Frances Healey,[2] Graham Neale,[3] Richard Thomson,[4] Charles Vincent,[3] Nick Black[1]

Learning, candour and accountability

A review of the way NHS trusts review and investigate the deaths of patients in England

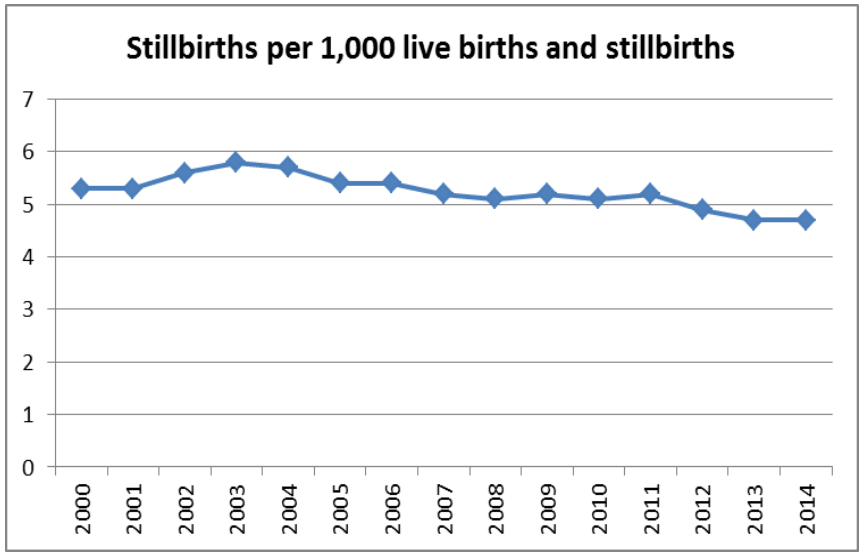
Range of related research proposed and in progress via Policy research programme:

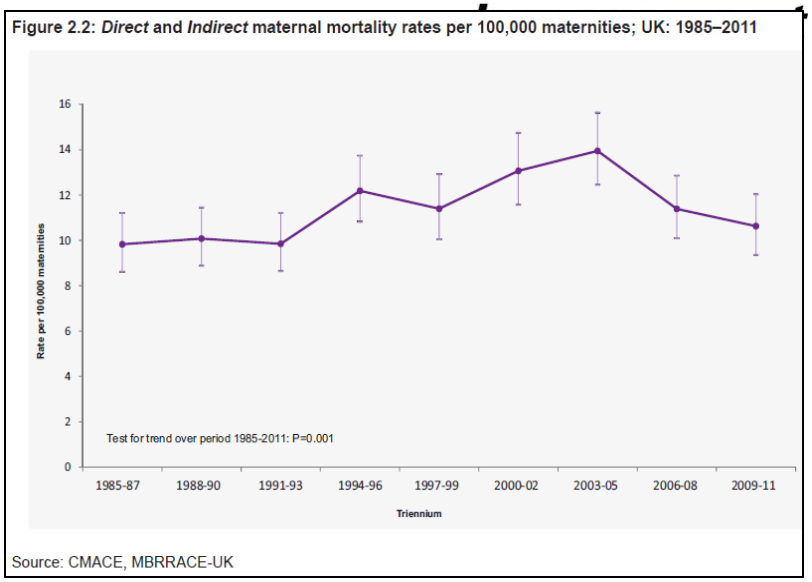
- Scale and nature of serious harm in primary care
- Scale and nature of severe harm due to problems in healthcare
- Medical Examiners and identification of preventable deaths due to problems in healthcare

Imperial College London

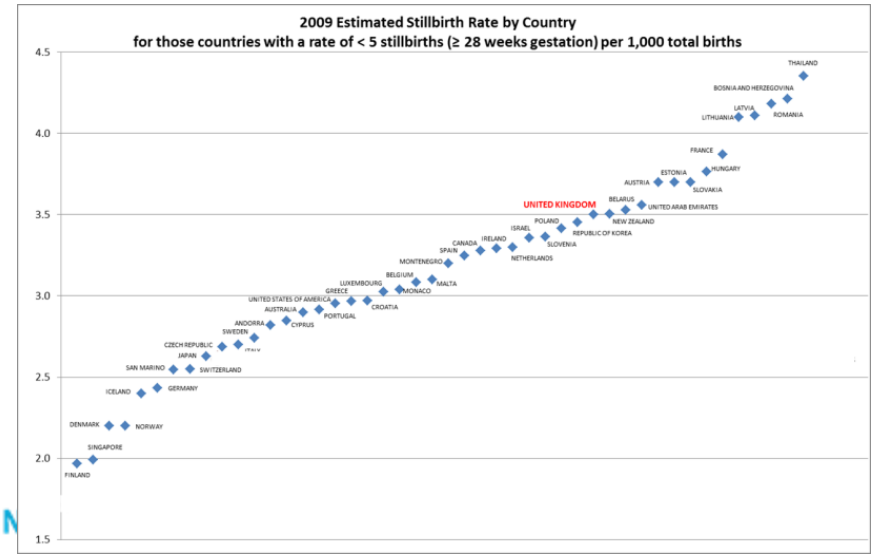
We have made some progress in recent years in reducing adverse outcomes in maternity services…

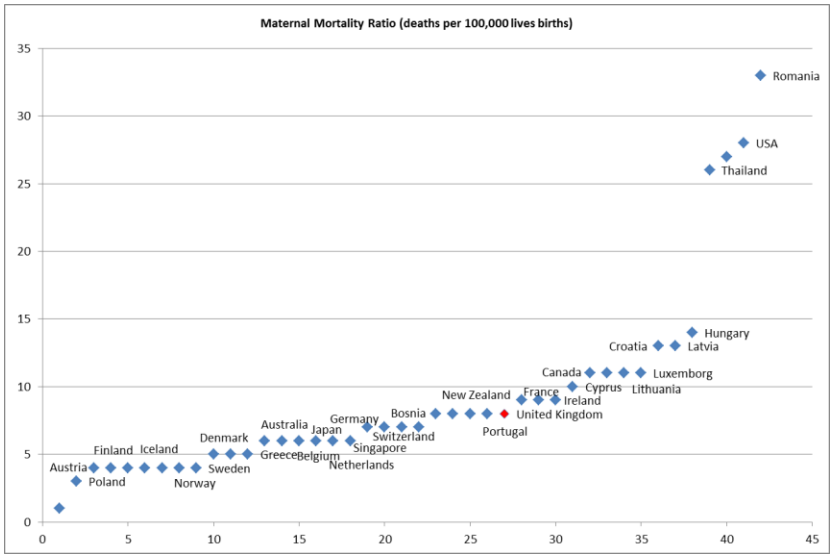
NHS





…but we need to stretch ourselves if we are to rank amongst the best countries in the world.

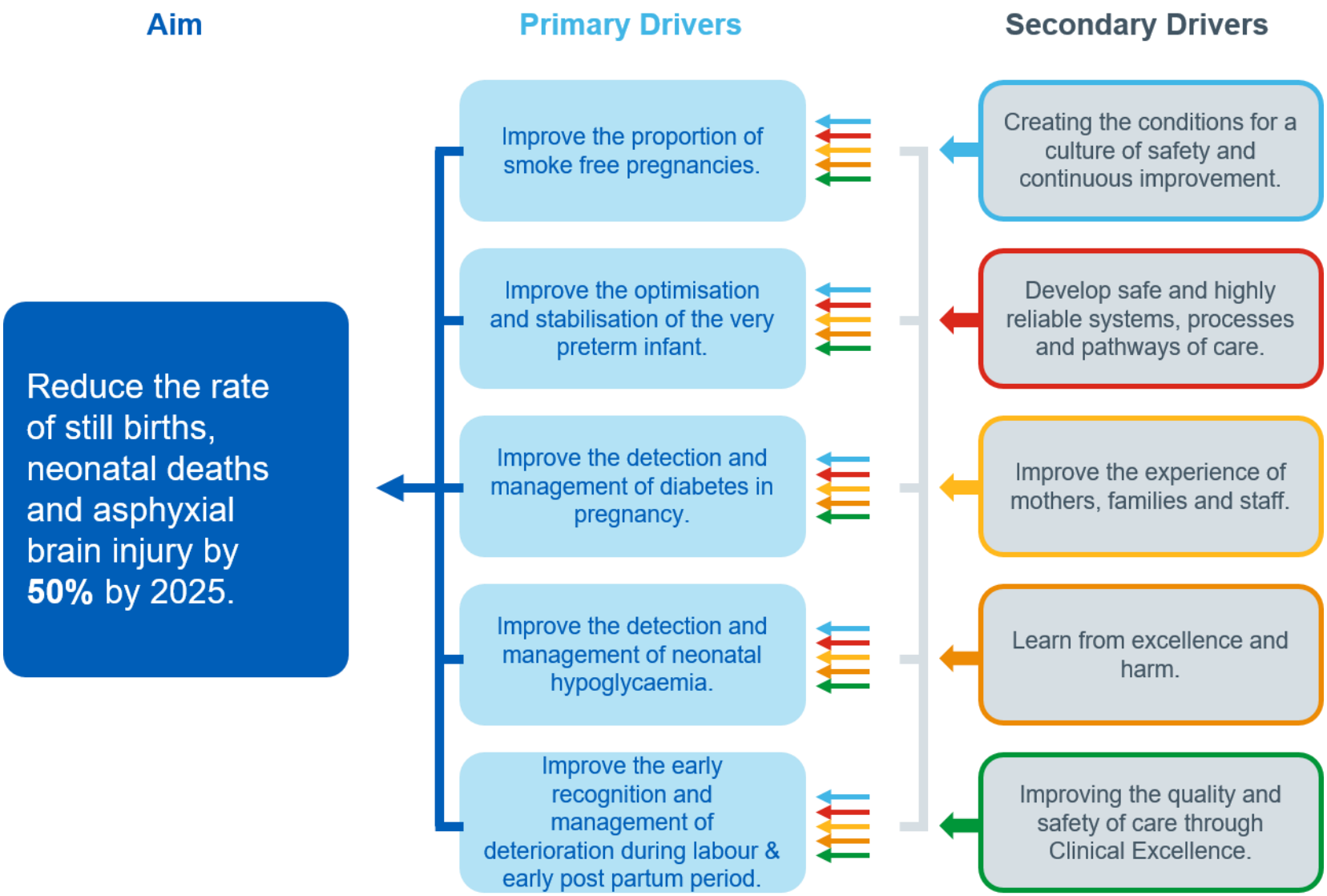




Imperial College London

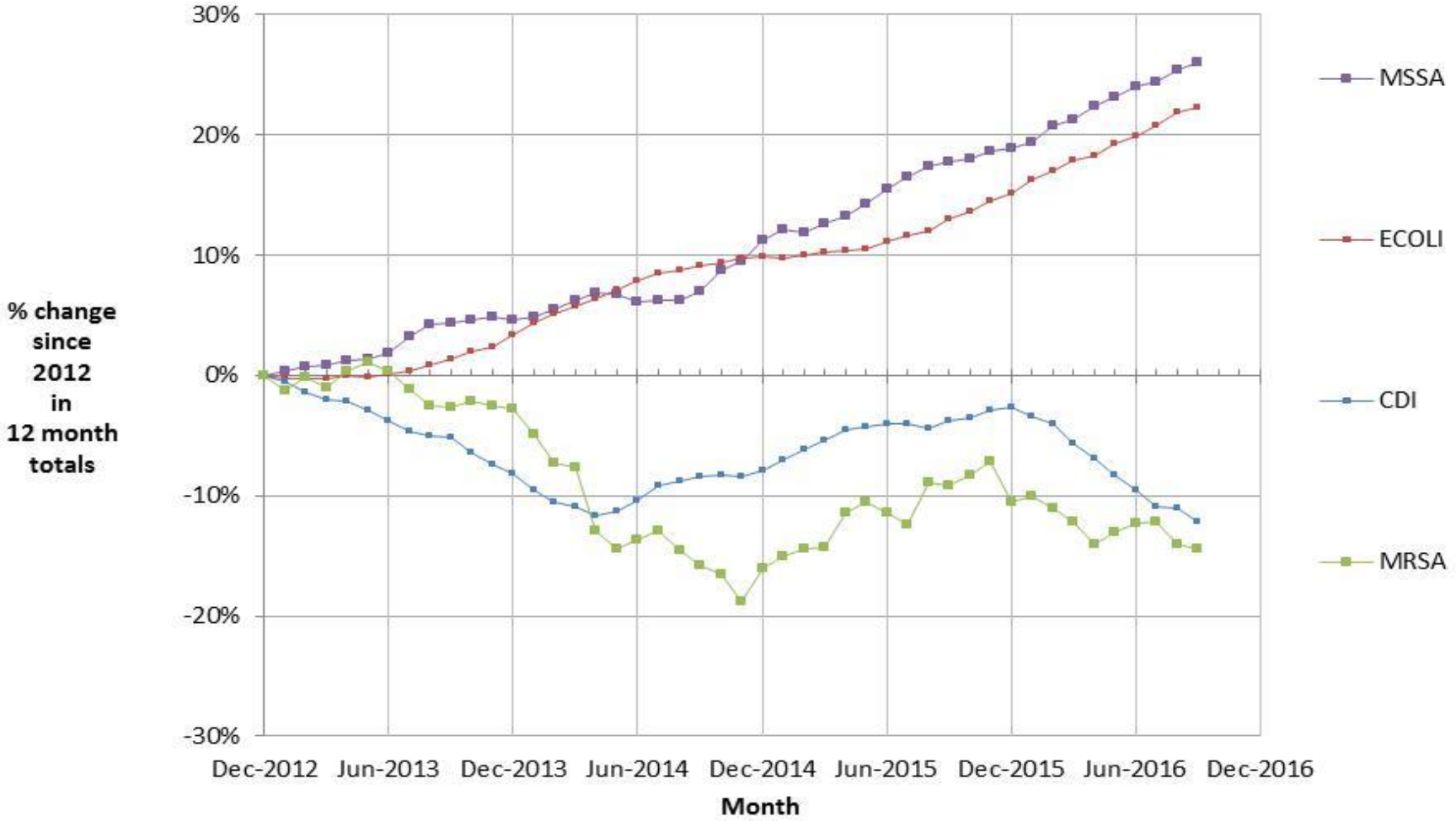
The Maternity and Neonatal Safety Improvement Programme

NHS



C. difficile infections and MRSA, MSSA and *E.coli* bloodstream infections % change in rolling 12 month totals since the calendar year 2012. December 2012 to September 2016

NHS Improvement



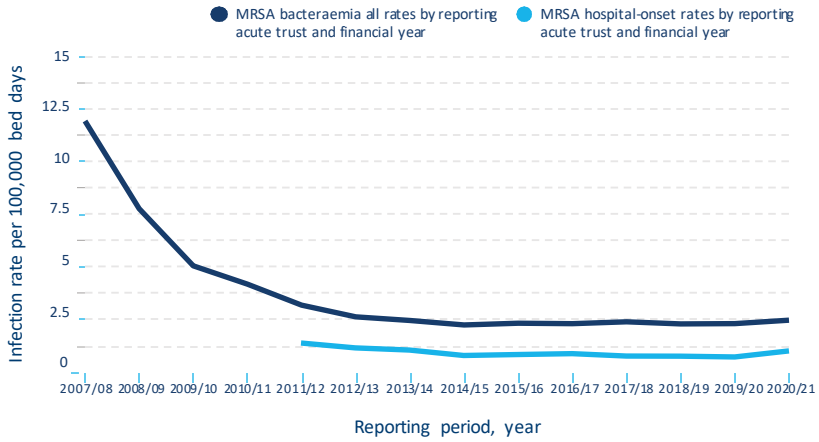


Figure 8: Rates of reported MRSA between 2007/08 and 2020/21.

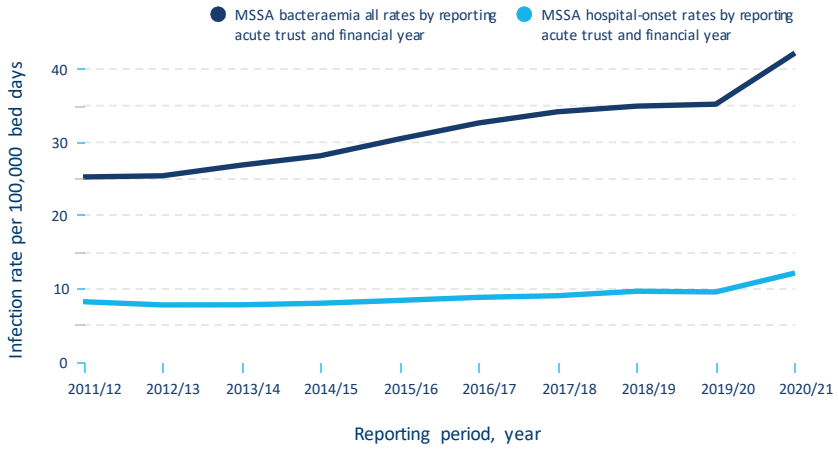
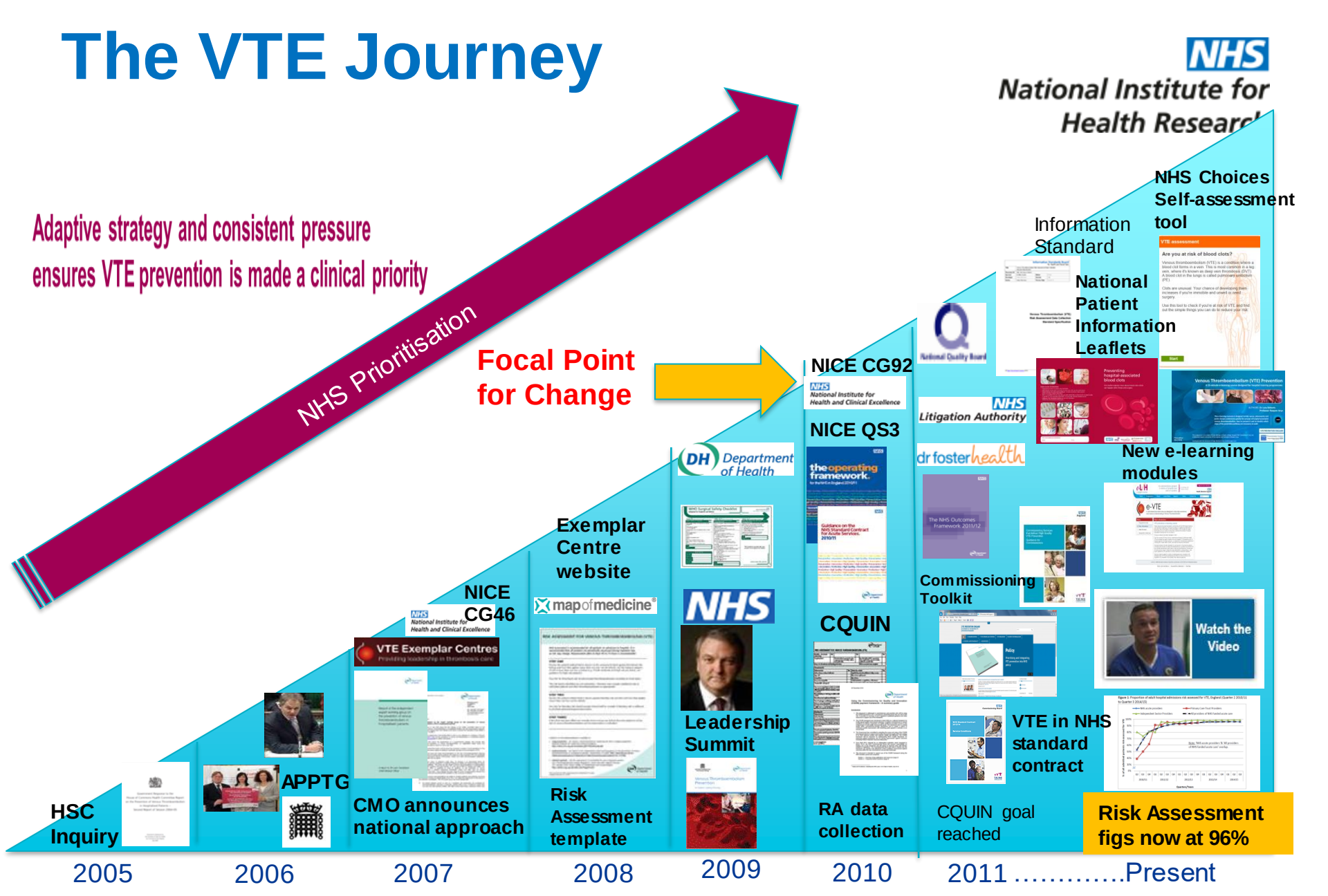


Figure 9: Rates of reported MSSA between 2011/12 and 2020/21.

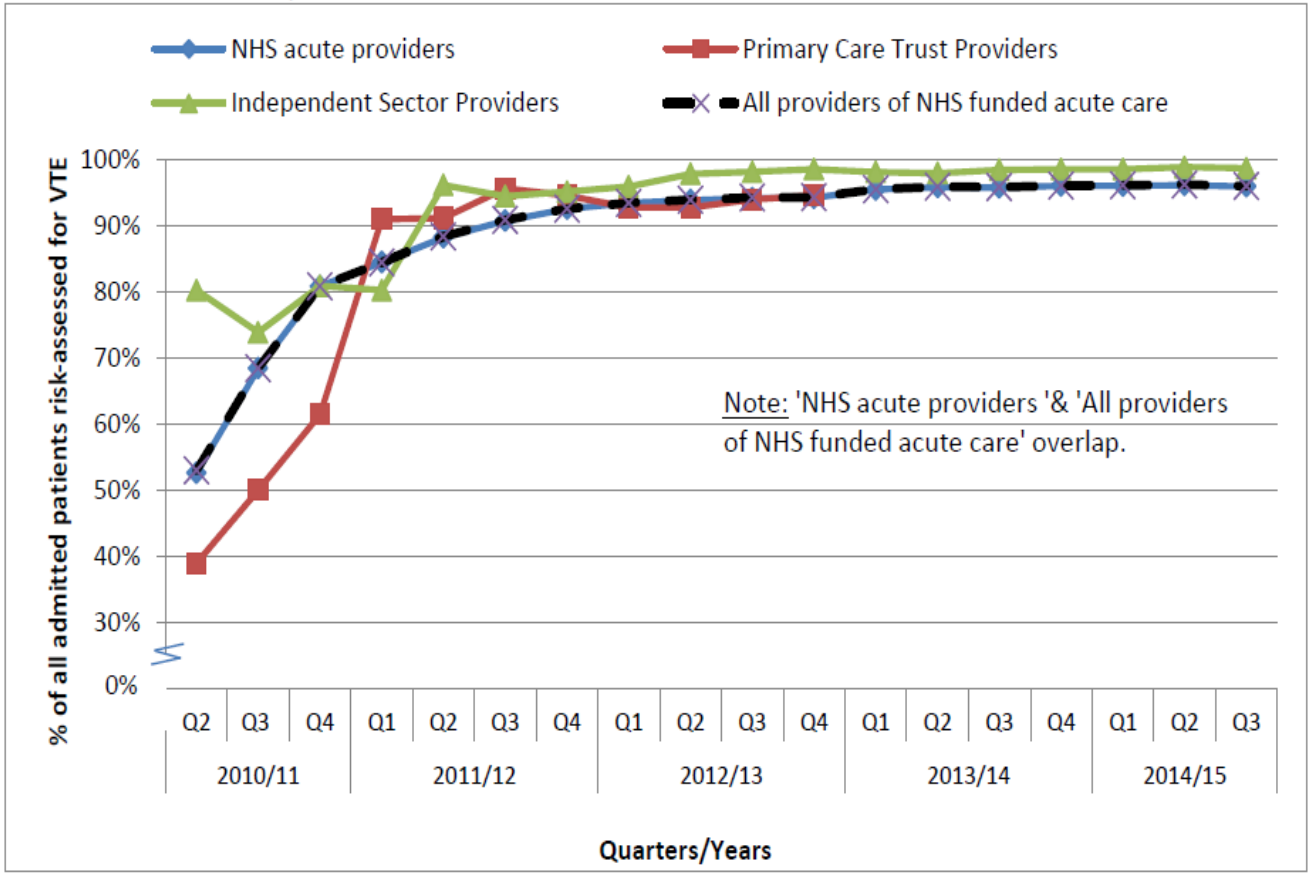
The VTE Journey



The impact of CQUIN

National Institute for Health Research

Figure 1: Proportion of adult hospital admissions risk assessed for VTE, England (Quarter 2 2010/11 to Quarter 3 2014/15)

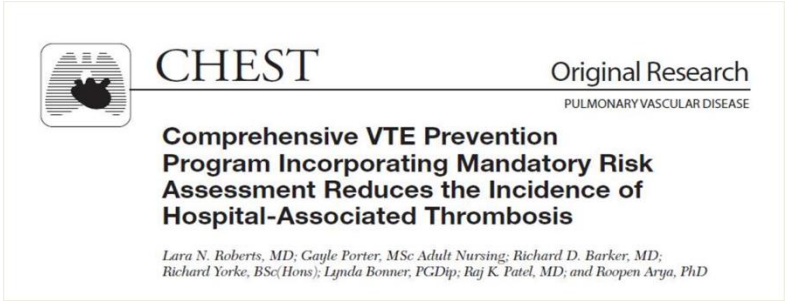


Improving Outcomes

NHS National Institute for Health Research

ONS data shows 9% reduction in VTE deaths since 2010
Improvement corroborated by 3 studies:

- QI data at trust level: increased risk assessment, decrease in rates of HAT, increased rates of appropriate TP, reduction of inadequate prophylaxis,
- QuORU: 15% reduction in mortality nationally when 90% risk assessment goal reached
- Catterick & Hunt: around 940 deaths owing to VTE have been avoided in England.

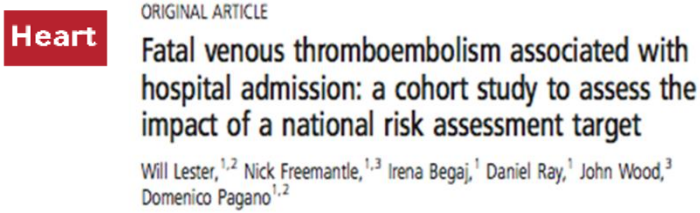


CHEST Original Research

PULMONARY VASCULAR DISEASE

Comprehensive VTE Prevention Program Incorporating Mandatory Risk Assessment Reduces the Incidence of Hospital-Associated Thrombosis

Lara N. Roberts, MD; Gayle Porter, MSc Adult Nursing; Richard D. Barker, MD; Richard Yorke, BSc(Hons); Lynda Bonner, PGDip; Raj K. Patel, MD; and Roopen Arya, PhD



Heart

ORIGINAL ARTICLE

Fatal venous thromboembolism associated with hospital admission: a cohort study to assess the impact of a national risk assessment target

Will Lester,[1,2] Nick Freemantle,[1,3] Irena Begaj,[1] Daniel Ray,[1] John Wood,[3] Domenico Pagano[1,2]

Blood Coagulation and Fibrinolysis 2014, 25:00–00

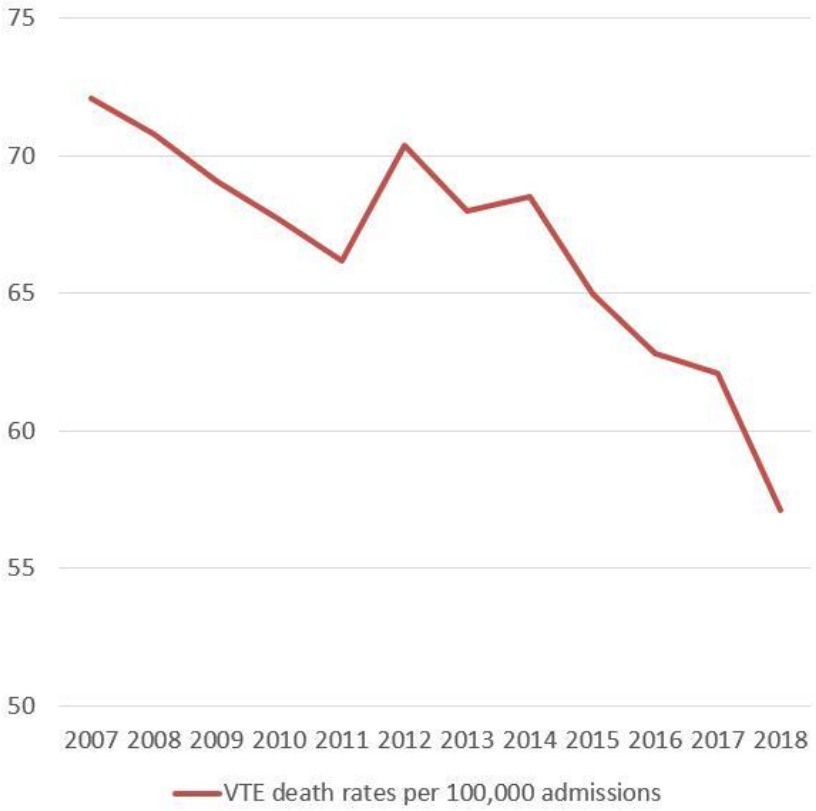
Impact of the national venous thromboembolism risk assessment tool in secondary care in England: retrospective population-based database study

David Catterick[a,b] and Beverly J. Hunt[c]

Post discharge VTE deaths in England 2007/08 to 2018/2019

NHS Digital

20.8% reduction since the outset

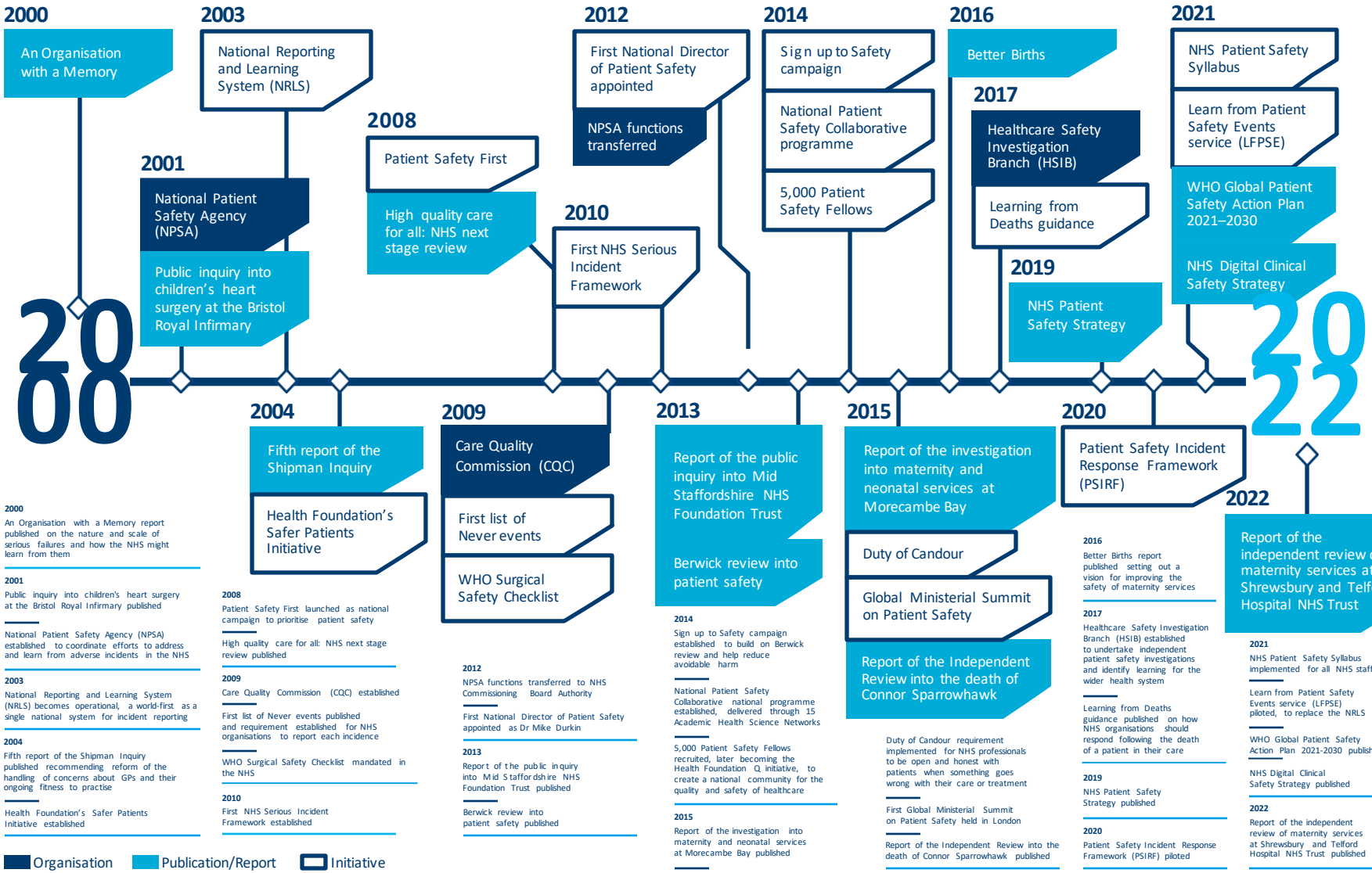


Imperial College London

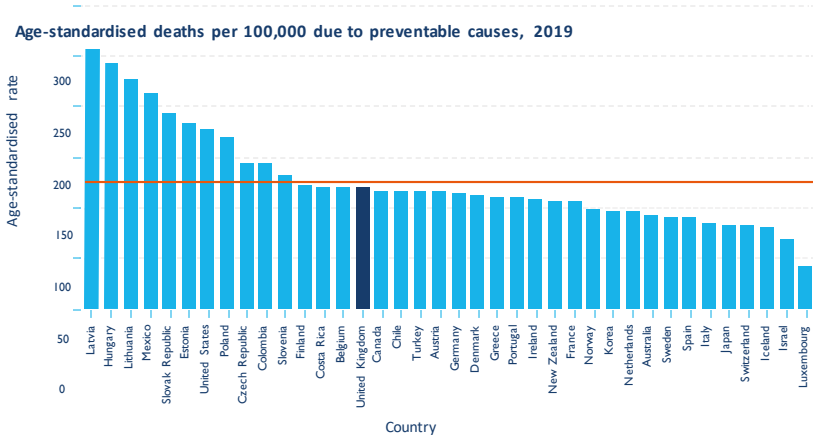
A timeline of landmark events in patient safety in England

This timeline[1] illustrates some of the landmark events in the evolution of patient safety in England since 2000, that have either accelerated progress or set a new direction for patient safety.

BACK TO CONTENTS



[1] Derived in part from: Sirrs C. NHS Patient Safety Timeline. Available from: https://warwick.ac.uk/fac/arts/history/chm/research/current/hazardoushospitals/patient-safety-timeline/ [Accessed 26 July 2022].



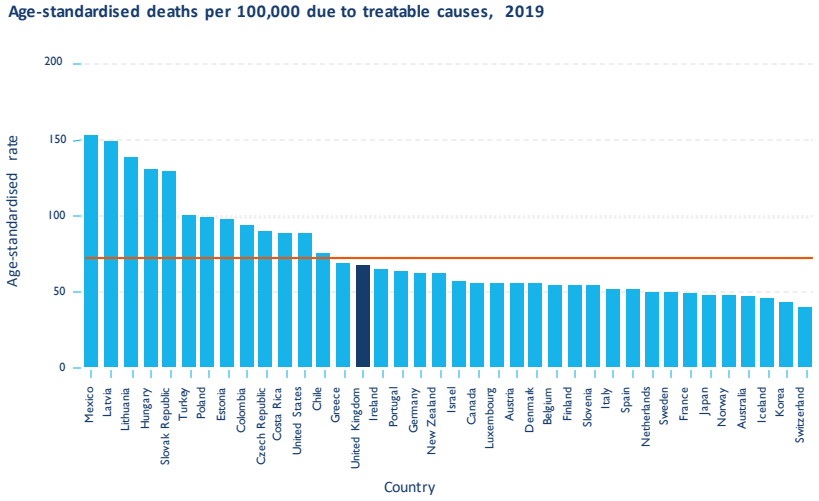


Figure 2: Age-standardised deaths per 100,000 due to preventable and treatable causes in OECD countries. Red horizontal lines indicates the average across all OECD countries. Note: UK figure was calculated using up-to-date data from the Office for National Statistics using the same OECD methodology.

NHS
National Institute for Health Research

Unsafe care is one of the

top 10

leading causes of death in the world [2]

up to **83%** of harm is **avoidable** [3]

It is estimated that

1 in 4

patients are harmed whilst receiving primary and ambulatory care [7]

In 2013, over **420 million hospitalisations** each year around the world resulted in nearly

43 million **adverse events** [8]

In hospital care, it is estimated that

75% of adverse events occur **in LMIC * contexts** [8]

***LMIC** = Low and middle income countries

"As of May 2019, patient safety has been enshrined as a global health priority via a World Health Assembly Resolution"

"Patient safety is not a luxury…it is the cornerstone of quality care everywhere"

"Ultimately, unsafe healthcare accounts for more lives lost than either lung cancer, diabetes or road injuries"

Poor quality care accounts for

10% to 15%

of the total deaths **in LMICs** [2]

Of the more than 130 million births occurring each year

2.6 million **result in stillbirth,** and another **2.7 million** **result in a newborn death** within the first 28 days of birth [12]

Every day **830** **women die from preventable causes** related to pregnancy and childbirth [11]

Nearly **600** frontline maternity staff in the **UK** demonstrated a **palpable concern for safety** [14]

In the US alone, the **economic cost of unsafe care** has been estimated at

$1 trillion

putting the global figure in the

MULTI trillions [3]

Medication errors alone across the world account for

$42 billion annually [15]

Harm often results in hospitalisations, accounting for over

6% of hospital bed days

and more than

7 million admissions

in OECD countries annually [7]

The **direct costs** associated with tests, treatments and care required **following harm in the primary and ambulatory setting** is estimated at

2.5% of total health expenditure [7]

"The economic case for safety is two-fold: first, the impact of harm has costly implications for remediate health and productivity loss; second, the initiatives dedicated to rectifying unsafe practice can be resource intensive and require detailed scrutiny to ensure their effectiveness."

"15% of all acute care activity is caused by harm occurring in hospitals ."

"From a patient perspective, the personal experience of harm can be catastrophic in terms of trauma, both physical and psychological."

In the US, where investments have been made to improve safety, it is estimated that

$28 billion

has been saved in **5 years** [3]

The **annual cost of common adverse events in England** is equivalent to hiring

2,000 GPs

or 3,500 hospital nurses [3]

Estimates suggest that **in developed countries the cost of harm in primary and ambulatory care** can approach

3% of GDP [7]

In NHS **maternity services, claims relating to medical negligence** amount to

£2.1 billion

while **£1.9 billion** was spent on delivering babies in maternity care [3]

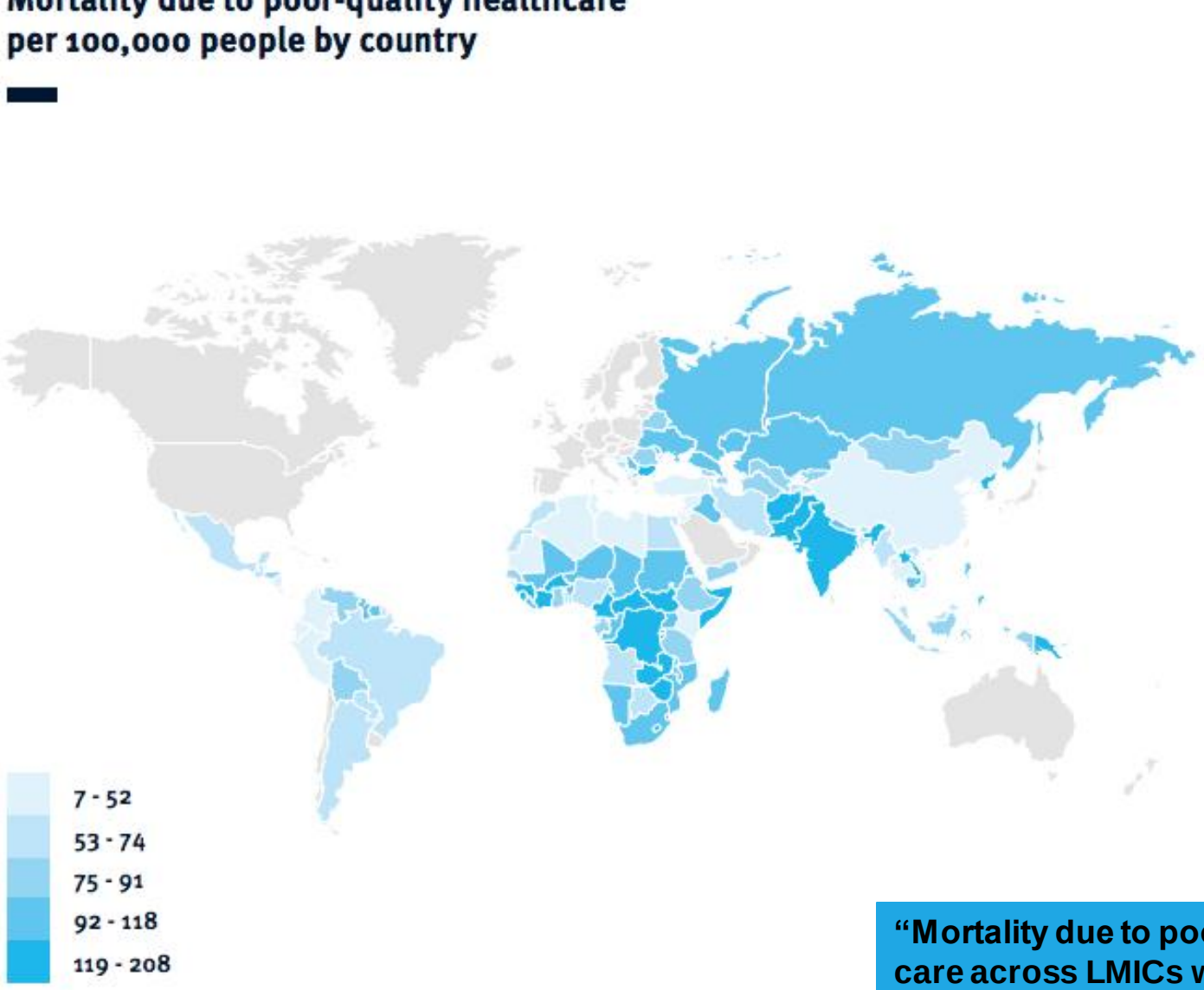


Figure 1. Mortality due to poor-quality health care by country. Reproduced from Kruk et al., 2018. [40]

"Mortality due to poor-quality care across LMICs was 82 deaths per 100,000 population"

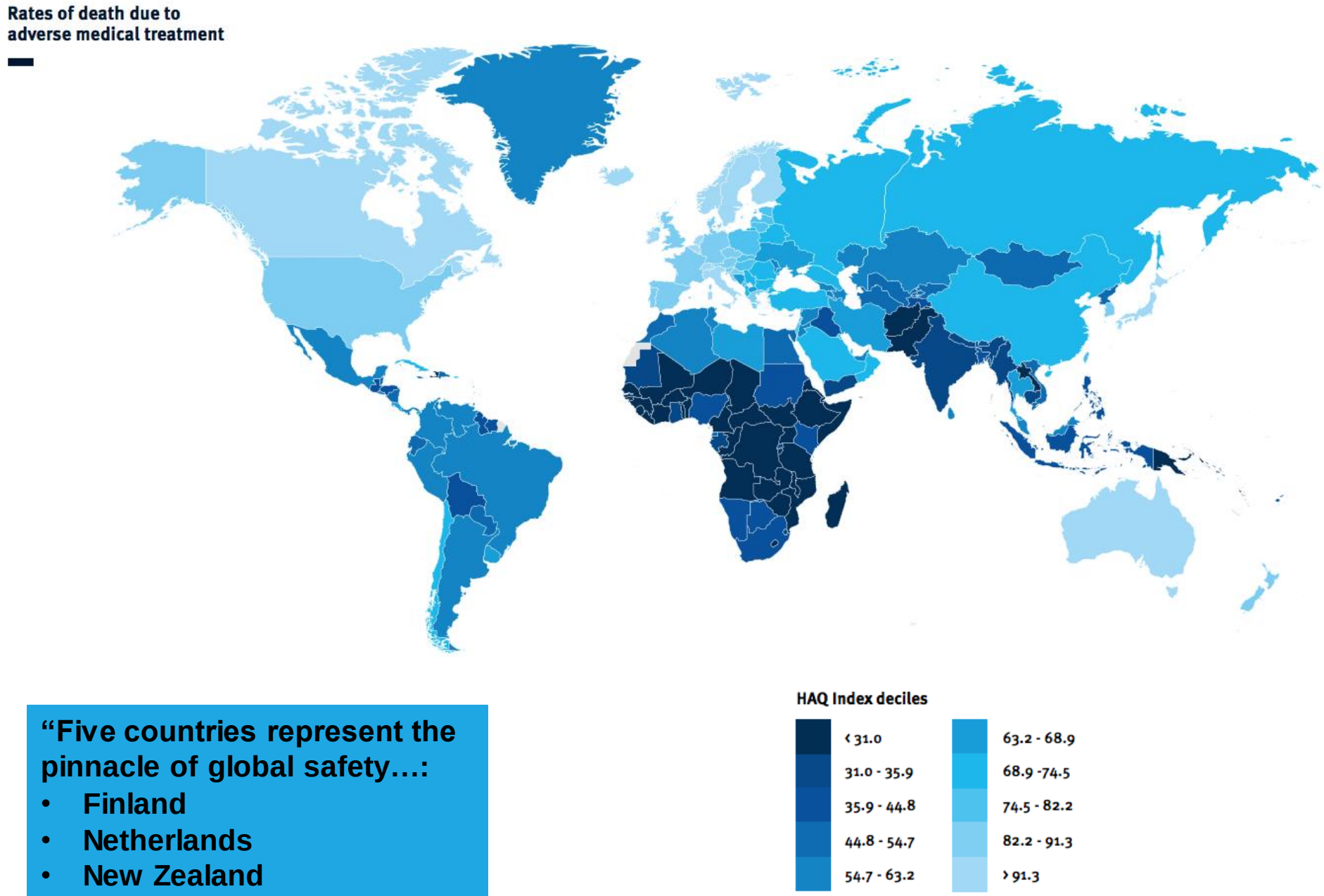


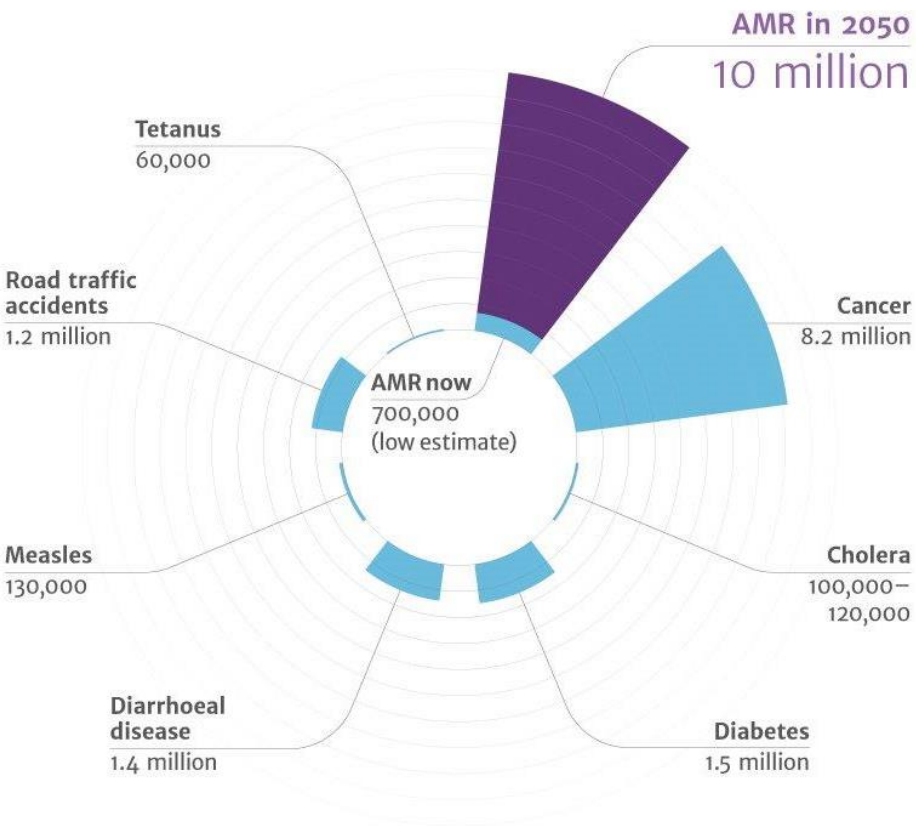
Figure 3. Rates of death due to adverse medical treatment.
Reproduced from GBD et al., 2016 with direct support from Prof Rafael Lozano.[41]

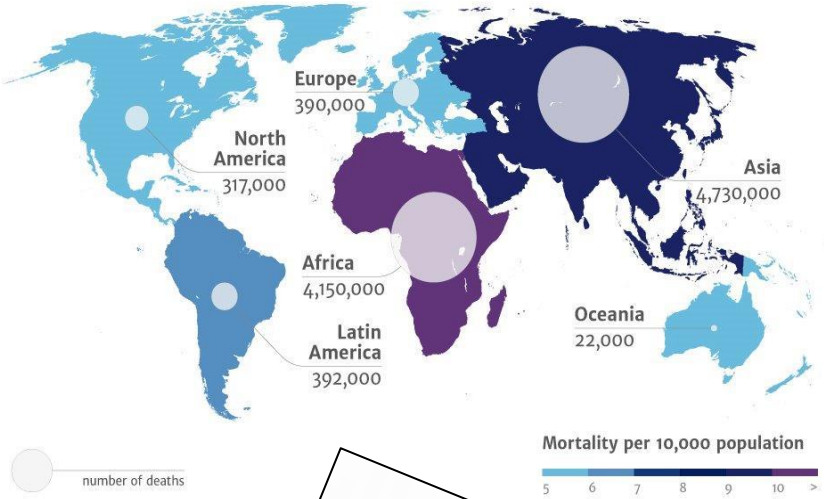
"Five countries represent the pinnacle of global safety…:

- **Finland**
- **Netherlands**
- **New Zealand**
- **Norway**
- **Singapore"**

AMR – a global healthcare threat

National Institute for Health Research





Imperial College London

Understanding Communication

- "Never assume communication has taken place.
- Never assume understanding has taken place."

ORIGINAL RESEARCH

OPEN ACCESS

Seven features of safety in maternity units: a framework based on multisite ethnography and stakeholder consultation

Elisa Giulia Liberati ,[1] Carolyn Tarrant,[2] Janet Willars,[2] Tim Draycott,[3,4] Cathy Winter,[4] Karolina Kuberska,[1] Alexis Paton,[5] Sonja Marjanovic,[1,6] Brandi Leach,[6] Catherine Lichten,[6] Lucy Hocking,[6] Sarah Ball,[6] Mary Dixon-Woods,[1] The SCALING Authorship Group

► Additional material is published online only. To view please visit the journal online (http://dx.doi.org/10.1136/bmjqs-2020-010988).

[1]THIS Institute (The Healthcare

ABSTRACT

Background Reducing avoidable harm in maternity services is a priority globally. As well as learning from mistakes, it is important to produce rigorous descriptions of 'what good looks like'.

Objective We aimed to characterise features of safety

outcomes.[1–4] Avoidable harm in childbirth can have devastating consequences for families,[5 6] and is an increasingly important driver of cost pressures in health systems through claims for negligence/

Commitment to safety and improvement at all levels, with everyone involved

Multiple problem-sensing systems, used as basis of action

Technical competence, supported by formal training and informal learning

Teamwork, cooperation, and positive working relationships

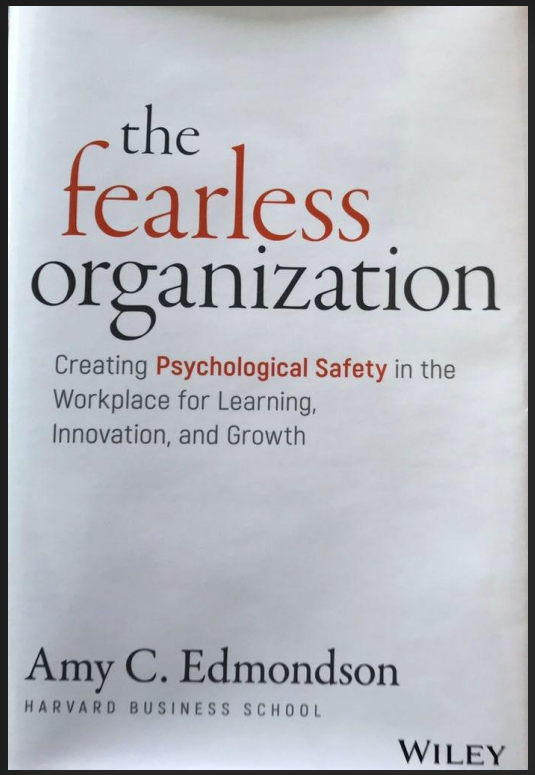
Constant reinforcing of safe, ethical, and respectful behaviours

Systems and processes designed for safety, and regularly reviewed and optimised

Imperial College London

Compassionate Leadership

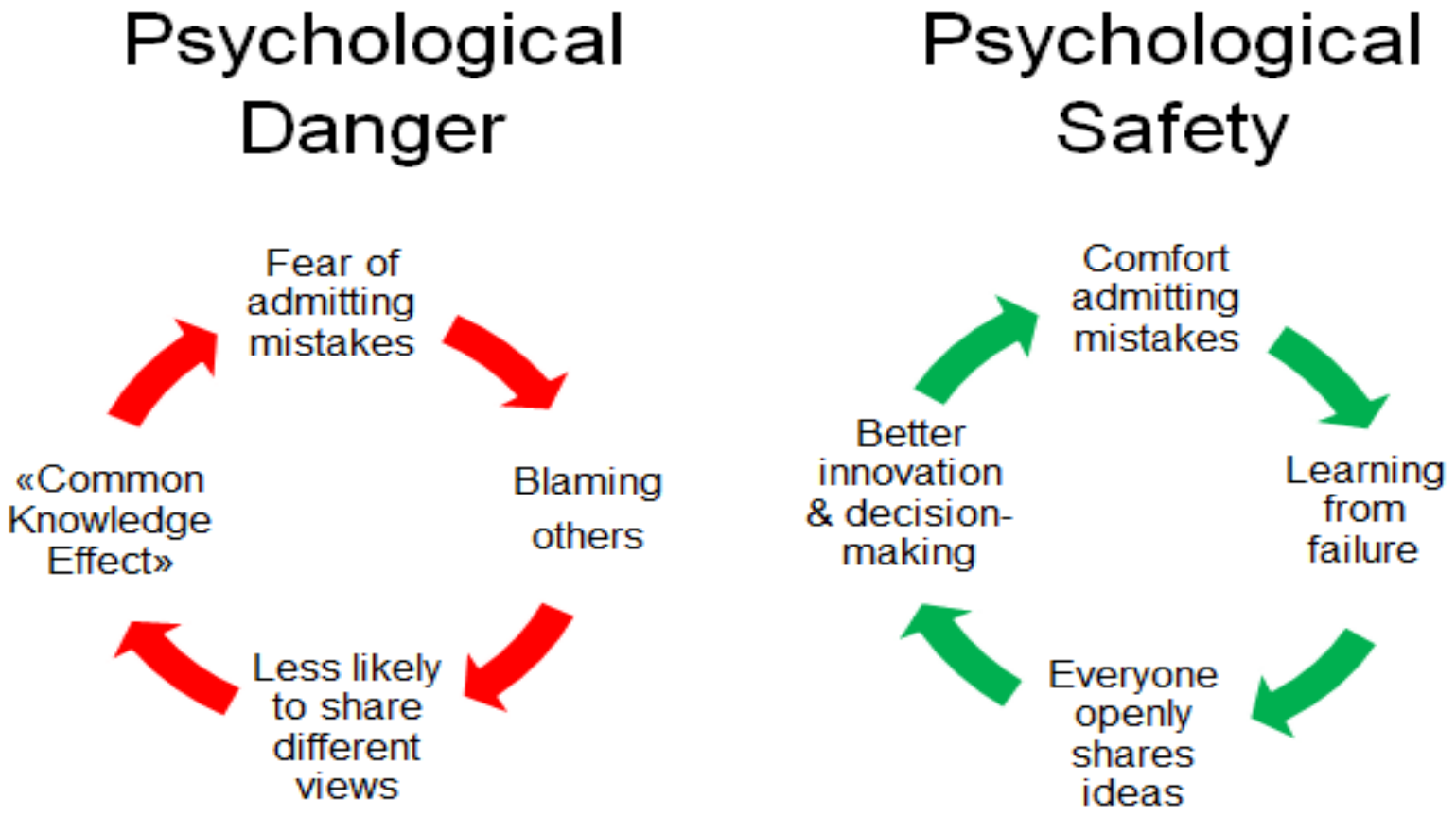
- "Compassionate leadership enhances the intrinsic motivation of NHS staff and reinforces their fundamental altruism. It helps to promote a culture of learning, where risk-taking (within safe boundaries) is encouraged and where there is an acceptance that not all innovation will be successful – an orientation diametrically opposite to a culture characterised by blame, fear and bullying.
- "Compassion also creates psychological safety, such that staff feel confident in speaking out about errors, problems and uncertainties and feel empowered and supported to develop and implement ideas for new and improved ways of delivering services. They also work more co-operatively and collaboratively in a compassionate culture, in a climate characterised by cohesion, optimism and efficacy."


the
fearless
organization
Creating Psychological Safety in the
Workplace for Learning,
Innovation, and Growth
Amy C. Edmondson
HARVARD BUSINESS SCHOOL
WILEY


Wellcome Images

Imperial College London

Creating Psychological Safety



Leading a culture of safety: Lucian Leape Institute

NHS National Institute for Health Research

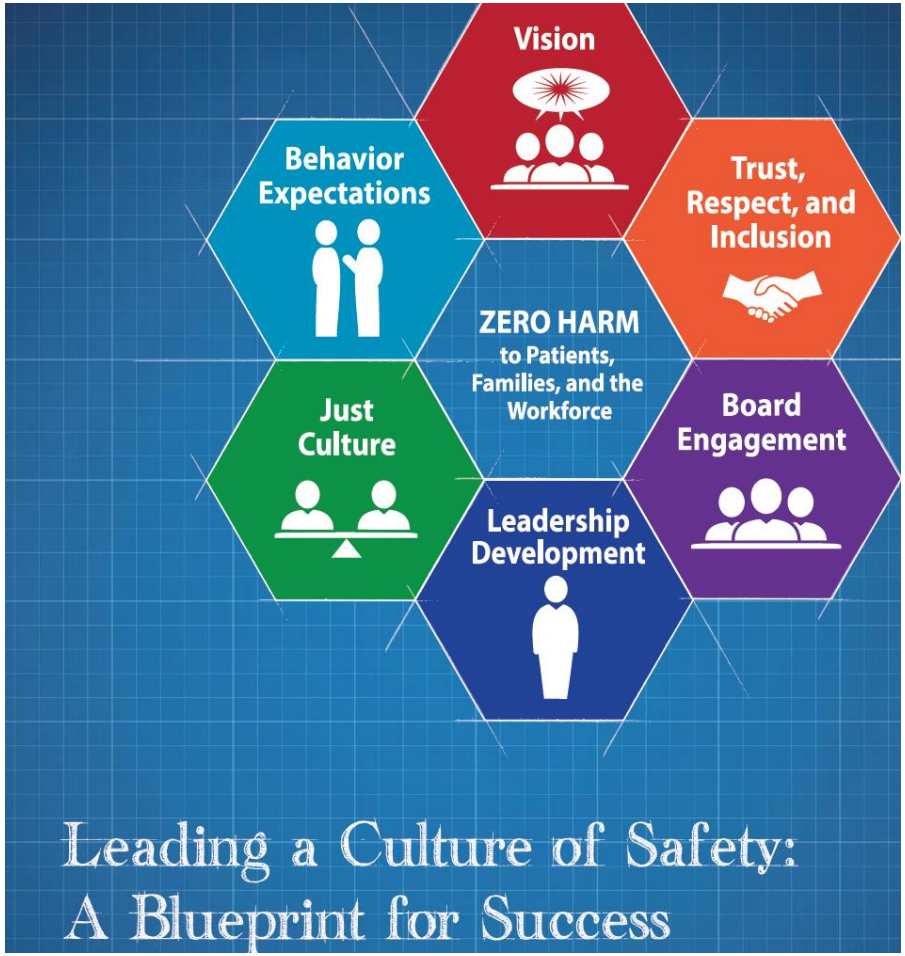
"…the aim of leadership is not merely to find and record failures of men, but to remove the causes of failure: to help people to do a better job with less effort."

"In God we trust, all others bring data."

Dr W. Edwards Deming

www.england.nhs.uk

11



Trust, Respect, and Inclusion

Value Trust, Respect, and Inclusion

The actions of leaders must be consistent over time and throughout the organization. Behavioral standards and expectations should apply to everyone, without exception. Respect for others—be they patients, family members, peers, or subordinates—is essential for creating and sustaining trust. Developing and holding all leaders and the workforce accountable to codes of conduct or code of ethics can help to solidify the practices and behaviors that encourage trust and respect (Chassin and Loeb 2013).

Beyond modeling behaviors of respect themselves, leaders may need to institute ongoing education for volunteers, students, clinicians, and the workforce about appropriate behavior, and continue to actively encourage changes designed to increase fairness, transparency, collaboration, inclusion, and individual responsibility (Leape et al., 2012).

In pursuing safety as a core value, trust, respect, and inclusion are fostered by CEOs who make and keep commitments to the workforce, who communicate when a problem cannot be fixed immediately, who consistently display a sense of fairness, and who engage in and encourage reciprocal, helping behavior throughout the organization.

CEOs must also display their trust in others. Creating a strong team enables leaders to have confidence in delegating decisions and authority, though trust does not mean believing nothing will ever go wrong. Leaders can expect to continually work on building, sustaining, or repairing trust.

Cultural Diversity and Respect in the Workplace

It is imperative that CEOs understand the cultural makeup of both the community and the organization in which they serve. Implementing and modeling behaviors that reflect a respectful and inclusive environment is essential to a culture of safety. This should include placing a high value on the positive impact of greater diversity and inclusion among leadership as well as the workforce. It should also include efforts to **evaluate and** eliminate disparities in patient care. Unleashing the potential of workforce diversity depends on the establishment of inclusion, the building of trust and [illegible] in skills and [illegible] an inclusive [illegible]ization. With [illegible]l diversity can [illegible]ce for creative [illegible] organizational [illegible] to identify [illegible]ities of care.

Just Culture

Lead and Reward a Just Culture

The hard work of establishing a just culture, however, goes well beyond agreeing to the concept itself. It involves incorporation of expertise in human factors engineering and systems design, full support and resources from the CEO and all leadership, and full engagement of departments such as Human Resources and Organizational Development. It also requires robust reporting systems with mechanisms in place to provide timely feedback to the workforce about not only what went wrong, but why it went wrong. This feedback also includes strong action plans to prevent future occurrence. Developing a just culture policy is just the first step, and organization-wide, systemic implementation is key.

While training of leaders and the patient safety workforce on just culture is vital, everyone at all levels of the organization must consistently integrate just culture principles as an organizational norm. The CEO's role in ensuring that just culture principles are understood and implemented across the organization is fundamental to success. If one individual within the organization is punished for a system flaw, just culture efforts can be severely undermined. Leaders must be transparent with the Board, physicians, the workforce, and the public about the organization's approach, so that when something does go wrong, the response is expected, practiced, and applied uniformly throughout the organization.

Just Culture Principles

Human behaviors within a just culture can be described as follows:

- **HUMAN ERROR** = An inadvertent slip or lapse. Human error is expected, so systems should be designed to help people do the right thing and avoid doing the wrong thing.
  Response: Support the person who made the error. Investigate how the system can be altered to prevent the error from happening again.
- **AT-RISK BEHAVIOR** = Consciously choosing an action without realizing the level of risk of an unintended outcome.
  Response: Counsel the person as to why the behavior is risky; investigate the reasons they chose this behavior, and enact system improvements if necessary.
- **RECKLESS BEHAVIOR (NEGLIGENCE)** = Choosing an action with knowledge and [illegible] disregard of the risk of harm.
  Response: Disciplinary action.

Board Engagement

Select, Develop, and Engage Your Board

An engaged Board plays a key role in organizational culture and safety. The CEO encourages Board competencies and commitment regarding safety, while providing a transparent line of sight between the Board and the rest of the organization.

Organizational Readiness Level	Foundational	Sustaining
Tactics *Examples of tactics that may be implemented to create change at each of these levels*	**To engage your organization:** ✓ Establish Board Quality and Safety Committee with oversight responsibility for culture change, safety, and performance improvement ✓ Include an individual with safety and culture expertise on Board and appropriate committees, or ensure an advisor with these skills is	**To engage your organization:** ✓ Encourage the Board to link executive compensation to safety outcomes, while ensuring metrics chosen do not discourage safety efforts ✓ Include Board members on Guided leadership rounds ✓ Align Board dashboards to show

Behavior Expectations

Establish Organizational Behavior Expectations

Organizational safety behavior expectations are the daily demonstration of a true culture of safety. CEOs work with leaders and the workforce to develop these expectations and to personally demonstrate expected behaviors, while holding the leadership team accountable for doing the same.

Organizational Readiness Level	Foundational	Sustaining
Tactics *Examples of tactics that may be implemented to create change at each of these levels*	**To engage your organization:** ✓ Complete culture of safety surveys every 12-18 months and review with Board, leadership team, and workforce; set targets for improvement and take deliberate action to achieve them ✓ Stratify and track culture and safety metrics by sociodemographic variables that are important to the organization's community and develop plans to address any gaps ✓ Develop required processes for teamwork, communication, and handoffs among the workforce and with patients, using tools like SBAR, read back, "stop the line," briefings, and de-briefings ✓ Require, participate in, and give context for existing safety processes, including safety huddles and operational briefings, and use these opportunities as forums to build better teamwork and safety culture	**To engage your organization:** ✓ Require annual signatures on compacts for Board members, leaders, and the workforce that clearly define expected professional accountability behaviors ✓ Educate and explain to your organization and the public what you will be transparent about, and what limits may exist on transparency ✓ Design and implement a crisis communications policy and plan for both internal and external audiences ✓ Align and integrate organizational safety and respectful behaviors with all departments across the organization ✓ Provide feedback to employees when they report a safety issue, closing the loop and demonstrating how frontline callouts improve safety ✓ Recognize and reward individuals and teams for demonstrating positive safety behaviors and reporting

Patient safety goes beyond borders – we get better by sharing

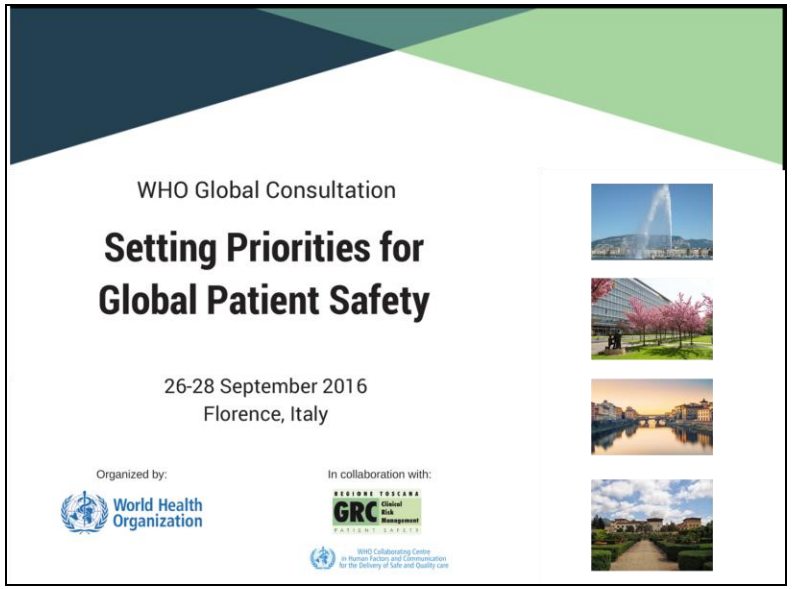
NHS Improvement

Patient Safety
Global Ministerial Summit 2017

Federal Ministry of Health

Patient Safety
Global Action Summit 2016

Department of Health



Patient Safety
MOVEMENT
zero preventable deaths by 2020

PaSQ
European Union Network for Patient Safety and Quality of Care

WHO Global Patient Safety Challenge

Medication Without Harm

Global Launch, 29 March 2017

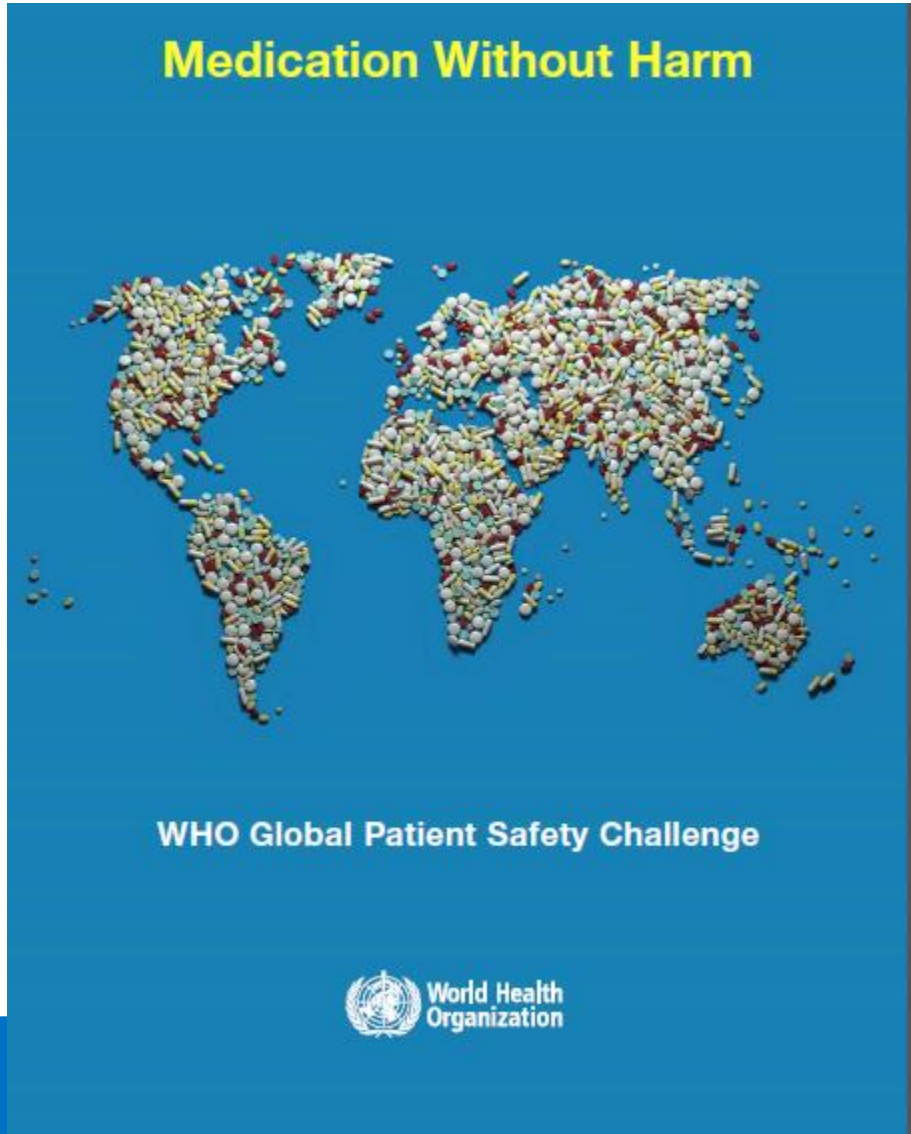
WHO Global Challenge

NHS
National Institute for Health Research

Reduce the level of severe, avoidable harm related to medications by 50% over 5 years, globally

- **Early priority actions.**

- • high-risk situations
- • polypharmacy
- • transitions of care



thebmj

BMJ 2018;362:k3424 doi: 10.1136/bmj.k3424 (Published 8 August 2018)

EDITORIALS

Check for updates

The Tokyo Declaration on patient safety

A new partnership between health workers and patients to promote safer care.

Kelsey Flott *centre manager*, Mike Durkin *senior adviser on patient safety and leadership*, Ara Darzi *director*

Imperial College London, UK

The 3rd Ministerial Summit for Patient Safety was held in Tokyo in April this year, with delegations from over 40 countries. The summit coincided with the publication of an Organisation for Economic Co-operation and Development (OECD) report, *Flying Blind,* which made an economic case for extending the patient safety movement to primary and ambulatory care, and further compelled international political interest in safety.[1]

We can no longer afford to ignore the burden of poor safety

It sets out actions for ministers—chief among them a commitment to "high level political momentum" towards the delivery of safer care everywhere. Further actions include renewed support for the World Health Organization's sustainable development goals and a proclamation to "align incentives, educate and train the healthcare workforce in patient safety, and engage patients and families."

Realising the declaration's full potential will require

Imperial College London

72nd World Health Assembly WHA Resolution (WHA72.6) May 2019 'Global action on patient safety'

- #patientsafety as a global health priority
- Concerted action to **reduce patient harm** in health care settings
- Historic establishment of **World Patient Safety Day** on 17 September

INSTITUTE OF GLOBAL HEALTH INNOVATION

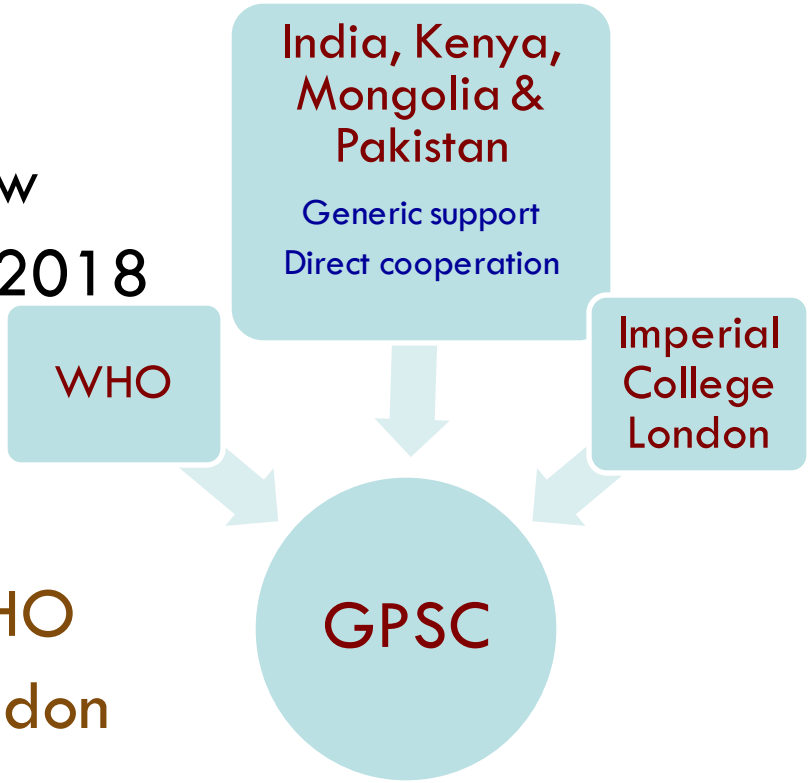
The Mandate

WHA 72.6: Global Action on Patient Safety

"to formulate a global patient safety action plan in consultation with Member States and all relevant stakeholders, including in the private sector, for submission to the Seventy-fourth World Health Assembly in 2021 through the 148th session of the Executive Board"

A Global Programme of Change

- WHO and DHSC, UK have co-developed and established a new strategic initiative in September 2018
- Focuses on the needs of LMICs to improve patient safety
- Implementation managed by WHO and PSTRC, Imperial College London



"A great example of the partnership between international organisations, academic institutions and emerging leaders in LMICs is the recently established Global Patient Safety Collaborative (GPSC)"

"The PSTRC will help facilitate and support the implementation of patient safety initiatives in the four countries, as well as sharing their knowledge on patient safety to successfully deliver the three capacity building programmes."

This programme will initially focus on three strategic objectives:

- Strengthen leadership in patient safety
- Develop knowledge base, expertise and skills in patient safety
- Promote and conduct targeted research in patient safety and build research capacity

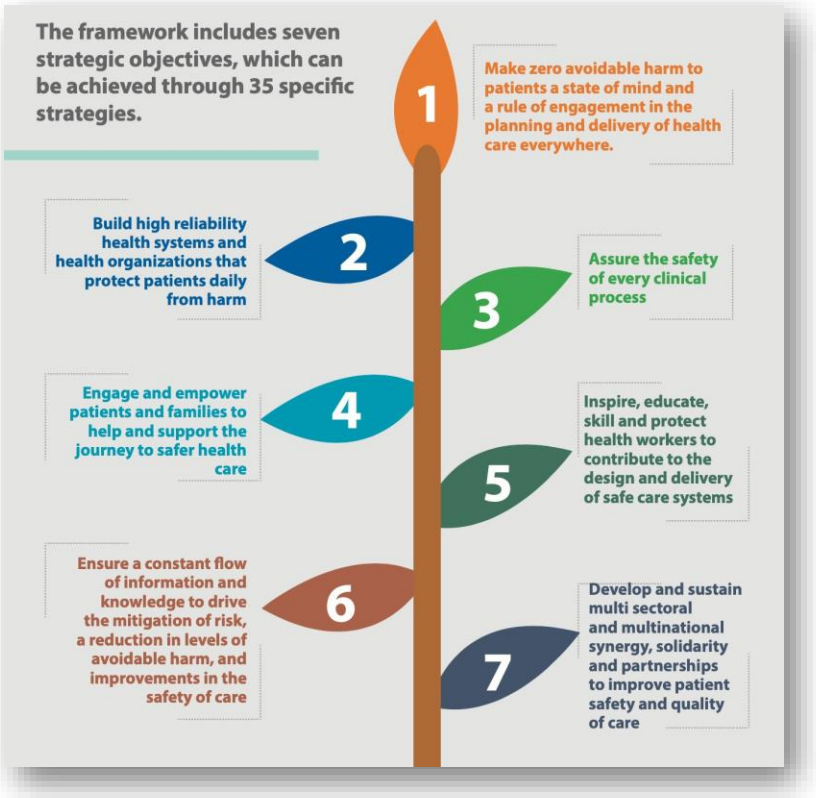
Global Patient Safety action Plan 2021–2030

Towards eliminating avoidable harm in health care

Patient Safety

World Health Organization

Strategic Objectives



Framework for Action

1. Policies for zero patient harm
2. High reliability systems
3. Safety of clinical processes
4. Patient and family engagement
5. Health worker education, skills and safety
6. Information, research, risk management and improvement
7. Synergies, partnerships and solidarity

Framework for action

1		**Policies to eliminate avoidable harm in health care**	1.1 Patient safety policy, strategy and implementation framework	1.2 Resource mobilization and allocation	1.3 Protective legislative measures	1.4 Safety standards, regulation and accreditation	1.5 World Patient Safety Day and Global Patient Safety Challenges
2		**High-reliability systems**	2.1 Transparency, openness and No blame culture	2.2 Good governance for the health care system	2.3 Leadership capacity for clinical and managerial functions	2.4 Human factors/ ergonomics for health systems resilience	2.5 Patient safety in emergencies and settings of extreme adversity
3		**Safety of clinical processes**	3.1 Safety of risk-prone clinical procedures	3.2 Global Patient Safety Challenge: *Medication Without Harm*	3.3 Infection prevention and control & antimicrobial resistance	3.4 Safety of medical devices, medicines, blood and vaccines	3.5 Patient safety in primary care and transitions of care
4		**Patient and family engagement**	4.1 Co-development of policies and programmes with patients	4.2 Learning from patient experience for safety improvement	4.3 Patient advocates and patient safety champions	4.4 Patient safety incident disclosure to victims	4.5 Information and education to patients and families
5		**Health worker education, skills and safety**	5.1 Patient safety in professional education and training	5.2 Centres of excellence for patient safety education and training	5.3 Patient safety competencies as regulatory requirements	5.4 Linking patient safety with appraisal system of health workers	5.5 Safe working environment for health workers
6		**Information, research and risk management**	6.1 Patient safety incident reporting and learning systems	6.2 Patient safety information systems	6.3 Patient safety surveillance systems	6.4 Patient safety research programmes	6.5 Digital technology for patient safety
7		**Synergy, partnership and solidarity**	7.1 Stakeholders engagement	7.2 Common understanding and shared commitment	7.3 Patient safety networks and collaboration	7.4 Cross geographical and multisectoral initiatives for patient safety	7.5 Alignment with technical programmes and initiatives

Red (high risk: take immediate action)

Many (but not all) children with these features are seriously unwell and need to be assessed straight away in hospital. Dial '999' for an ambulance if necessary.

Skin, lips and tongue

- Very pale or blue skin and sunken eyes
- Rash that does not fade when pressed firmly (use a clear glass)

Activity

- Not responding to carers
- Very difficult to wake up
- Weak, high-pitched or continuous cry in younger children
- Older children are confused or unusually irritable

Breathing

- Finding it much harder to breathe than normal
- Grunting breathing
- Very fast breathing: more than 60 breaths a minute
- Noticeable pauses in breathing

Circulation

- Very cold hands and feet

Temperature and body

- Under 3 months with raised temperature over 38°C
- The soft spot on an infant's head is bulging
- Stiff neck, especially when trying to look up and down
- The child has a seizure

Vomiting, diarrhoea and hydration

- Very thirsty and not able to keep fluids down
- Bloody or black 'coffee ground' vomit
- Not had a wee for 12 hours

Notes

NHS

SAM

Sepsis Assessment & Management




What to look for if your child has a temperature and you are concerned

“Systems awareness and systems design are important for health professionals, but they are not enough. They are enabling mechanisms only. It is the ethical dimensions of individuals that are essential to a system’s success. Ultimately, the secret of quality is love.”

Professor Avedis Donabedian

THANK YOU

m.durkin@imperial.ac.uk

@Mike_Durks