PSA Symposium: How can we successfully collaborate towards safer care for all

Collaborative learning for safer care: the Patient Safety Management Network

Tuesday 6 June 2023

patient safety learning

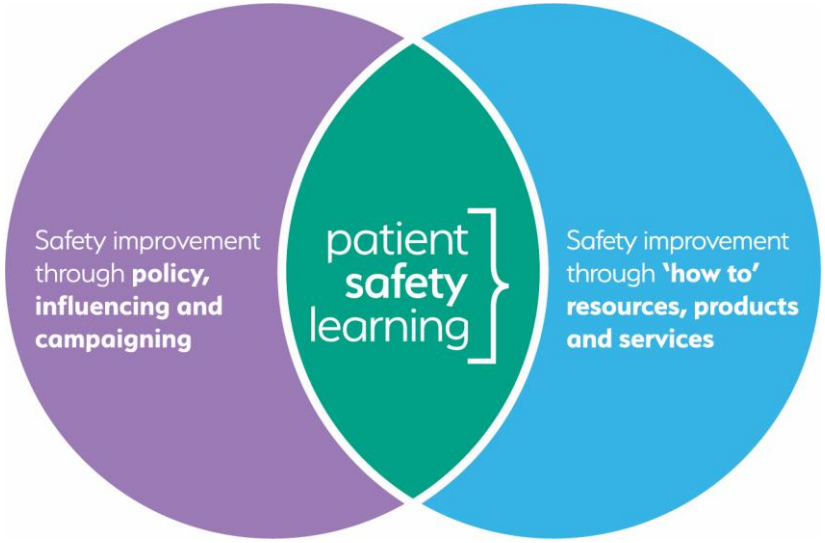
Presenters

- **Helen Hughes** - Chief Executive of Patient Safety Learning
- **Claire Cox** - Patient Safety Management Network Co-founder and Patient Safety Lead (clinical) at King's College Hospital NHS Foundation Trust
- **Chris Elston** - Patient Safety Education Lead at University Hospital Southampton NHS Foundation Trust

patient safety learning

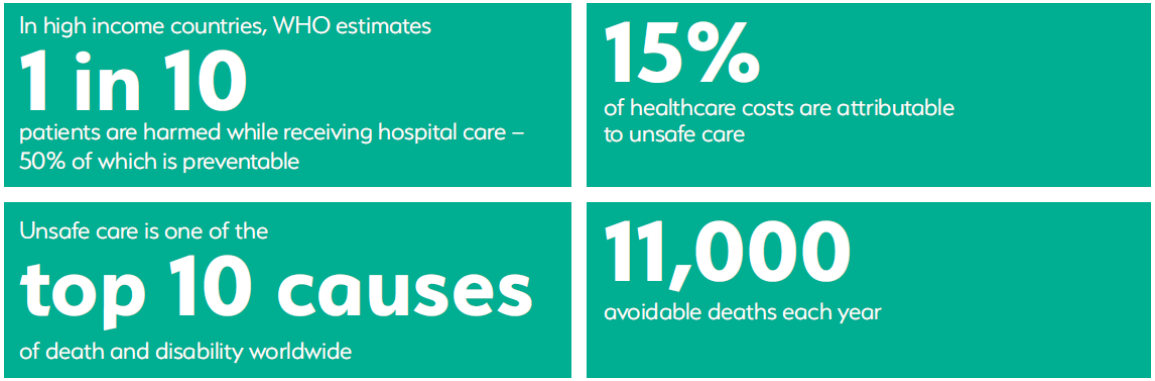
An independent charity for patient safety

- Founded 2018 as a voice for system-wide change
- Vision: to help create a world where patients are free from avoidable harm
- Mission & Purpose: to transform how health and social care organisations think and act in regard to patient safety



patient safety learning

Scale of avoidable harm in healthcare



- Patients want safe and effective care and assume that patient safety is a priority
- Yet despite the efforts and good work of many people to address patient safety issues, unsafe care continues to persist
- Have we normalised an unsafe system?

patient safety learning

What the patient safe future looks like

- Safety is a core purpose
- Leadership commitment and action for safety
- We drive out variation with safety comparison data
- Our staff are trained in safety
- We design for safety with human factors expertise
- We actively engage patients and families
- We learn from near misses & harm
- We take action to address causal factors of harm
- Healthcare has a just culture
- Staff are physically and psychologically safe
- We have high standards for patient safety

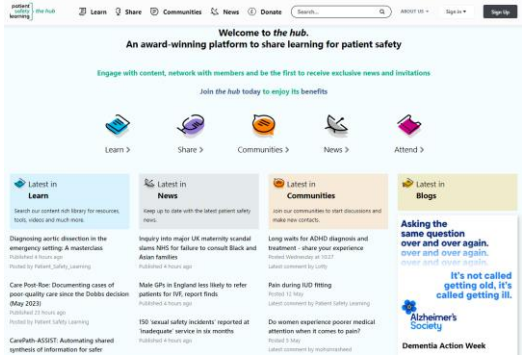
Healthcare operates as an effective safety management system

patient safety learning

patient safety learning

the hub www.pslhub.org

- Free patient safety platform
- Sharing knowledge for learning
- Publishing high quality content
- Promoting good practice and policy



patient safety learning

Patient Safety Management Network (PSMN)

- An informal voluntary network, created by and for patient safety professionals, established in June 2021.
- Hosts weekly drop-in sessions for its members, with guest speakers joining to talk through patient safety issues of importance.
- Opportunity for members to gain new insights and learning, access a point of peer support and have a safe space for discussion.

patient safety learning

Why is the Network needed?

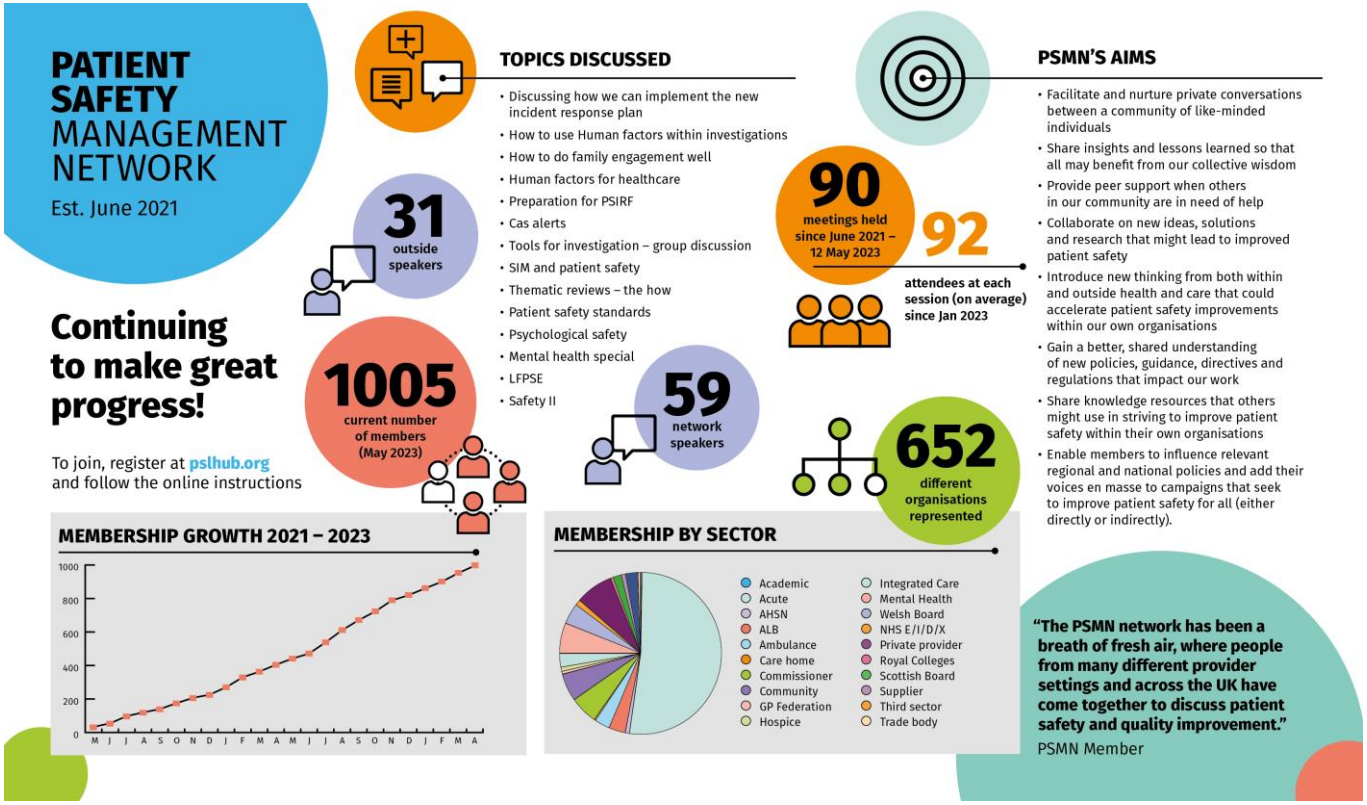
- There are numerous networks for healthcare professionals to join, however not within patient safety
- The rollout of the Patient Safety Incident Response Framework (PSIRF) promotes new ways of working, which require an understanding of the theory and how to apply this in practice.
- While Patient Safety Specialists are able to discuss the high level of implementation of this within the NHS, the PSMN is more informal, providing a forum to tackle the challenges and triumphs of implementation of the safety improvement including PSIRF
- Provides a means of accessing and sharing a huge amount of untapped knowledge and expertise within patient safety in every trust and healthcare setting whether that be private, NHS or independent

Aims of the Patient Safety Management Network

- To facilitate and nurture conversations between a community of like-minded individuals, sharing insights and lessons learned.
- Enable collaboration on new patient safety ideas, solutions and research/
- Introduce new thinking from both within and outside health and care that could accelerate patient safety improvements.
- To gain a better, shared understanding of new policies, guidance, directives and regulations that impact on its members' work.
- To influence relevant regional and national policies and add the PSMN voices to campaigns that seek to improve patient safety for all.

patient safety learning

How the Network has grown and developed



patient safety learning

The values and impact of the Network

- Gives everyone a voice no matter what their title or grade is
- The Network has allowed its members to connect and learn from experts from a range of different backgrounds, within and outside the NHS
- In the beginning we would source speakers, however now speakers ask to join to share their knowledge and learn
- Recognised by external stakeholders, with its members invited to engage in NHS England plans eg around family/staff support following serious incident
- The PSMN is getting the voice of its members heard and recognised
- A community of interest for cultural change, improvement and shared learning

What its members say

I love the network, this is a fantastic group of people who come together in a safe space to have honest conversations about the challenges we face and share knowledge of ideas so that we can try to make improvements. It is a joy to attend the meetings and make new connections.

A great place to come together with like minded people to learn and grow together in a safe place that fosters psychological safety.

1 hour of my week where I come away feeling that I have met with peers and extended my knowledge!

This network is my safe space, a weekly point in time to be inspired, share ideas and meet with like-minded people all trying to tackle the complex world of NHS patient safety. I have made so many networks from this group, and realised that we are not all alone in our challenges and opportunities to improve!

patient safety learning

And personal reflections from Chris and Claire

One of the most inclusive, collaborative forums I have been a member of - creates a safe space to support sharing of peer knowledge and experience - as much as possible I prioritise this hour together

It's the eagerly awaited punctuation mark of the week for me! An hour which I really look forward to where the space is safe to ask questions, share information and learn such a lot. As we all approach PSIRF and LFPSE it is so reassuring to find we all have similar concerns. Thank you, Claire and Helen, for your unstinting efforts over the past two years to ensure patient safety is no longer an isolated mission as you make everyone feel valued as part of the network

patient safety learning

What next?

- PSMN ‘the book’ – to be published 2024
- Other patient safety networks, established and agreed
  - NatSSIPs – safe surgery network, 540 members
  - Community Hospitals
  - Patient Safety Partners
  - Directors with Patient Safety leadership

patient safety learning

Discussion

patient safety learning