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Report

High-level forum

Global action on patient safety

Thursday 2 – Saturday 4 May 2019 | WP1692

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In association with the United Kingdom's Foreign and Commonwealth Office and the Department of Health and Social Care

Executive summary

The Wilton Park High Level Forum on Patient Safety convened experts from around the world to discuss priorities in patient safety at a global level. The two-day concentrated discussion covered the articulation of the burden of harm, possibilities to drive action towards improvement and the various roles different stakeholders play in fostering a culture of continuous improvement for safer care. High level findings can be summarised as follows:

High level findings

There is an opportune 'policy window' for change in patient safety

1. According to Kingdon's political theory, there are three ingredients for a policy window to open: a problem, a political intention to improve and a policy solution (1). In the case of patient safety, there is a clear problem articulated through statistics and personified through patient stories; there is a political will to improve, as declared during the Patient Safety Ministerial Summit Series; and there is evidence of effective solutions and a promising innovation pipeline. The World Health Assembly (WHA) Resolution, adopted three weeks after this meeting, is providing a global 'policy window' of opportunity, which will require a concerted effort to implement. Patient Safety cannot stand alone in this effort and implementation will require partnership across all stakeholders in Universal Health Coverage (UHC).

The burden of unsafe care is clear and evidence-based both locally and globally

2. Across the world $42 billion is spent every year on medication errors. In the UK in 2018 there were 344 never events[1] and 10,000 patients died from infections which could have been prevented (2). In London alone patients filed 35,000 complaints – that's nearly 100 per day (3). These customary safety indicators, however, do not tell the full story. There are new and emerging threats to the quality of care and safety of patients, for example in terms of antimicrobial resistance, which is projected to kill 10 million people by 2050, and a safety-induced public health crisis, as adverse events result in 23 million Disability-Adjusted Life Years (DALYs) lost per year (4). The clinical and public burden is further substantiated by the OECD's seminal report, Flying Blind, which demonstrates the economic burden and significant return on investment for safety initiatives (5). Additionally, despite evidence-based innovations, lessons from other industries and patient stories, there is an 'implementation gap' when it comes to instigating improvement.

[1] a never event is an NHS term used for adverse events that are serious, largely preventable, and of concern to both the public and health care providers for the purpose of public accountability

Momentum towards safer care is building at local, national and international levels

3. Participants in the Wilton Park High Level Forum on Patient Safety identified tailored strategies for catalysing action for safer care. Working groups delved into the complexity, focusing on the toughest challenges: safe cultures in Low and Middle Income Countries (LMICs), enshrining patient involvement in all health systems and squaring the notion of "to err is human" with the public call for "zero harm."

Culture is equal to policy and public momentum in order for safety innovations to land, take root and flourish

4. There is a clear need for a change of organisational culture in many health settings. Culture is not an accident nor an immovable force, but a shared objective, which patients suggest can be achieved with a greater degree of humility. It relies on the ability to speak up, to innovate and the acceptance that some innovations will fail. The cornerstone of culture is communication and there is a need for a new language around patient safety that recognises the priorities of patients and staff, striking a balance between culture and accountability The impediments to a positive safety culture are more profound in LMICs and low resource settings which face enormous challenges to deliver on Universal Health Coverage (UHC) and build patient safety measures into that. Furthermore, leadership in these areas is at a premium because it is not always sustained nor prioritised given demanding clinical needs; resource for training is scarce; and the technical expertise to design, develop and deploy cultural innovations is limited.

In order for safety opportunities to materialise, they require a concerted effort towards collaboration, innovation and education

5. Dialogue towards safer systems resulted in shared priorities as well as concrete actions to take forward. Forum participants unanimously supported for the World Patient Safety Day on September 17th, part of the WHA resolution for safety. The overarching themes for action were collaboration, innovation and education.

6. Improved safety will require unfamiliar partnerships, deeper creativity and training that is accessible to patients, providers and policy makers. Participants were committed to support this and shared their investment in the success of the WHA resolution. It was recognised that too often governments and health systems strive to be the safest in the world, when in fact, the real opportunity is to create a safer world together.

7. A series of collaborative actions were also put forward to build safer systems and share good practice:

Agreed actions

Create national learning systems

Ensure meaningful collection and responses to patient feedback

Develop curricula for patient safety including curricula for investigations

Develop local and global portals for sharing ideas and best practice

Design systems to prevent harm with aligned priorities

Collect data about impact and evaluation

Harness existing digital innovations to improve patient safety.

Context and aims

Context

8. Patient safety is a result of practice, patients and policies, both local and global. Therefore, engendering safer care requires the commitment and shared responsibility of policy makers at all levels and healthcare staff, in close partnership with patients, families and carers. These perspectives shape the agenda for change, which is set out in this report.

9. The High-Level Forum was a unique opportunity to gather the leaders of patient safety from around the world, where patient safety initiatives have translated to safer care. This includes not only those countries who lead by example and have hosted Ministerial Summits, but also to include low and middle income countries (LMICs) where the ability to develop national patient safety strategies and implement them is often compromised. Over 50 participants took part, representing 29 countries. The UK Foreign Secretary, the Department of Health and Social Care Minister, Caroline Dineage, the UK's chief medical officer Sally Davies and a number of senior officials from the WHO contributed to the dialogue. Central to the discussion were contributions from patients or their relations, with a number of personal stories highlighted which demonstrated the tragic consequences of harm and the impact it has had on individuals and their families.

Aims

10. This report articulates the global state of patient safety and sets out the objectives for providing safer care, establishing safer health systems and building more positive cultures, as agreed upon by global experts in patient safety.

The Patient Safety movement

11. Across the world we spend $42 billion every year on medication errors alone (6). In the UK in 2018 there were 344 never events which are adverse events that are serious, largely preventable, and of concern to both the public and health care providers for the purpose of public accountability (2). 10,000 of our patients died from infections which could have been prevented and here in London, our patients filed 35,000 complaints – that's nearly 100 per day (3). Over the six-month period from July to September 2018, 488,242 incidents were reports to the National Reporting and Learning System from England, compared to 153 when the system first was used in 2003 (7). The statistics surrounding patient safety are stark, and further details about the specific burden of certain types of harm is delineated below, but the numbers are even more compelling when accompanied by the real-life patient stories which they represent.

12. Throughout the High-Level Forum, patient stories were woven into the fabric of the conversation, demonstrating the centrality of patient partnership in the movement towards safer care. These stories exposed the enduring personal and social impact of harm on an individual, a family and a staff member.

13. These figures and stories compel a human urgency to improve and optimise safety, a mission which has already started.

A brief history of patient safety

14. Since the publication of *To Err is Human* and *Crossing the Quality Chasm*, patient safety has grown from an area of interest to a recognised priority and a cornerstone of global quality in a matter of decades. Vast quantities of data about safety now exist, such as those captured by the UK (NRLS, which has over 12 million data points about safety incidents). The quest to gather safety information, combined with increased patient agency, has brought safety into the limelight and galvanised clinical and ministerial support.

The Patient safety movement today

15. The ministerial summit series, formally called the Patient Safety Global Action Summit, convened its fourth successful event in Jeddah in February 2019, following previous summits held in London, Berlin and Tokyo, and continues to reach new countries every year, including more involvement from LMICs. These types of conventions not only jumpstart commitment, but also provide a forum for sharing best practice and raise awareness of many already tried and tested tools for safety. Organisations like the Patient Safety Movement Foundation (PSMF) support this work by breaking down siloes between all the stakeholders in patient safety and unite towards an aim of zero preventable harm.

16. The context of a clear and defined problem, shared political commitment to solve it and availability of effective solutions creates an ideal foundation for a policy window (1). This current policy window in patient safety provided context for this High Level Forum, as well as the determination and responsibility to act. It prompts possibility and requires swift proactivity.

17. In order to capitalise on this policy window, the Forum conversation focused on articulating the burden of harm, as understood by a range of stakeholders, tactics for generating new momentum and opportunities for building safer cultures, and culminated in a shared consensus for action. It exposed a diversity of thought and resulted in a congruence of priorities, highlighting the unbridled potential for collaboration not only across geographies, but across settings and sectors.

The global burden of unsafe care - a diversity of perspectives

18. One of the first topics discussed was antimicrobial resistance (AMR) and its relationship to patient safety. Each year, 60,000 babies die of drug related sepsis. Today, 700,000 people die of anti-microbial resistance, a number which is projected to increase to 10 million by 2050 (8). The link to safety is not only in terms of morbidity: anti-microbial resistance drives hundreds of thousands into poverty as a result of prolonged illness and protracted recovery times (9). The responsibility may have been put clearly to clinicians in many countries, but the reality is that antibiotic stewardship is relevant to the public before they are patients. In parts of the Ganges River, for example, the level of antibiotics is assessed to be similar to those in the bloodstream of a patient taking antibiotics.

19. AMR is not the only emerging threat exposed; public health concerns with safety and the levels of misdiagnosis in LMICs were also brought to light. Although the patient safety community focuses on the $42 billion spent on medication errors, international experts argued that this number is likely dwarfed when considering how many diagnoses are not made, and never treated. Experts also warn of a safety-induced public health crisis, as adverse events result in 23 million DALYs lost per year (4).

20. The human burden speaks for itself, but the economic one has been carefully researched, as outlined by the OECD’s report Flying Blind (5). The report puts costs to harm and a value to safety, but it also poses a question for all health system leaders, what are the best buys in terms of patient safety interventions?

21. While “best buys” may be possible, it is clear that even where interventions do exist, the burden of harm is compounded by an implementation gap. Furthermore, the safety challenge has been deemed a “silent epidemic” because of these problems but also due to certain laws that prohibit constructive dialogue. The situation is exacerbated in less resourced areas where there is a lack of basic and minimum equipment necessary for safety and a data gap, which prohibits the ability to analyse the situation locally.

22. The burden of harm is multifaceted and requires a policy commitment at an international level reinforced by public knowledge and aligned priorities across the health sector and beyond.

Building momentum for safe care

23. Turning the numbers on safety around and creating an environment which pre-emptively combats emerging threats, will be propelled by leaders' enthusiasm, but will only be sustained with multi-layered strategy and collaboration. The High Level Forum explored plans for building momentum towards safer care, including viable strategies for filling the implementation gap and co-creating innovations.

24. The burden of unsafe care is transparent, stark and globally recognised. These are the first ingredients to developing an urgency to the patient safety movement and stimulating momentum. However, to take meaningful action, strategic policies and practices are needed that apply at a local, national and international level as well as key principles that apply to the movement as a whole.

25. Separate working groups for national, international, and patient and public strategies were constructed to discuss a multi-faceted approach to shifting the paradigm for global action.

National strategies

26. National policy for safety focused largely around national patient safety organisations and their roles and responsibilities. Ultimately, regardless of the existence of a national group responsible for patient safety, it was clear that there needed to be a government owner of a business case for safety.

27. A comprehensive business case for safety includes a vision of shared responsibility rather than simply a re-articulation of facts and return on investment. For instance, a business case for safety should convince a finance director of a hospital of the centrality of safety to all business development.

28. Beyond establishing business plans at the country level, incentivising quality is paramount. It is not enough for the health system alone to promote safe care, but for all sectors to work together to make safety a reality. A clear requirement for successful national policy is 'patient to politician' partnership. It was thought that if any group is alienated from the dialogue, including politicians, it can curtail the window of opportunity for meaningful change.

International strategies

29. This group focused on galvanising partnership and mobilising at the highest levels. The advent of Safety II, or learning from best practice, has spurred international leaders in patient safety to focus on how to recognise what has gone well and investigate replication rather than remediation. Strategies like this can be built into global curricula for safety accessible to LMICs as well as more developed health systems.

30. Behaviourally, it is apparent that rewards and recognition for good practice have a far greater motivational pull than learning from mistakes. This can be harnessed at an international level through awards schemes which could be enshrined within existing conventions like the Patient Safety Global Action Summits. Harnessing new forms of social media can engage the public with the safety movement, enhanced by working with relevant celebrities to promote the cause.

Patient and public strategies

31. The evolution of the patient safety movement has advanced from an interest in patients experience, to a true partnership with patients. Over time, patients and members of the public have been afforded more agency to represent their lived experience of care within policy level discussions.

32. As familiar as patient and public involvement is in European and North American health systems, it remains 'foreign' in many countries and contexts. Even where the principle is well established, patients continue to observe the health system operating

reactively to safety incidents, rather than proactively in response to their stories.

33. Patient partnership for patient safety has always revealed the level of understanding between care professionals and the patients they treat; it is clear that the intention to provide first rate care is nearly always evident, and the intention to be an active partner in care is nearly always present. However, these ideals are too often compromised by the reality of healthcare provision in terms or resource, time and most of all, communication. Patients conveyed that communication was the key to unlocking meaningful partnership. As one patient expressed, “to cultivate optimism, we need a louder voice,” demonstrating the need for a communication strategy to break down the language barrier that can stand between patients and professionals.

34. Most error does not equal harm and problems arise for staff when error cannot be learned from, but also for patients when error is not properly communicated or understood. The communication issue extends outside immediate care provision; it is clear that patients assume safety when they enter into hospital. Promoting safety is about maintaining transparency to a degree that patients are aware of the issues and can proactively speak up if needed, however it is a fine balance to avoid shifting the burden of responsibility to patients. Rather, co-creation is central to partnering with patients and to do so, it is necessary to embolden new generation of safety leaders by working in schools, developing training programmes, leveraging social media and taking advantage of what has been called “new power” or the type of power cultivated by grass roots movements, that is shared and proliferated through accessible media (10).

35. A diversified package of strategies to ignite the patient safety movement is critical, but partnership, innovation and education are central.

Partnership

36. Capitalising on the current policy window requires use of existing resources, which are mostly related to human capital and potential for collaboration. Following successful summits, Ministerial enthusiasm is a critical resource. Other global conventions for instance, the World Health Assembly, which has just taken place only a few weeks after the High Level Forum on Patient Safety is another prime opportunity to embed safety into a larger health debate. Furthermore, existing international collaborations such as the G7 offer different vehicles for partnership.

37. In addition to high level partnership, the frontline responsibility for enacting the patient safety changes envisaged should play a more prominent role. While patient stories have been strongly positioned on a global stage, frontline experience and ideas for improvement have not. Drawing sufficiently on all levels of partnership is critical for momentum at the international, national and local level.

Innovation

38. Innovation in patient safety may simply be another form of partnership with a more creative face. Addressing safety problems will not be improved with the same thinking that has addressed them for decades; an injection of fresh thinking is needed, whether from other industries, professionals or countries.

39. This includes embracing digital innovations that promise to impact on patient safety, quality of care and patient-centredness. Innovative workforce models are emerging, for example Health Education England’s workforce strategy to be published imminently will contribute to this discussion.

40. The airline industry, as well as other high-risk industries, can provide an example of how safety practice can be improved, rather than being held as the definitive gold standard. Lessons from these industries will require adaptation to have relevance in healthcare, but it is the job of patient safety experts to work across industries and understand how to translate these learnings to healthcare.

Education

41. One of the most important barriers to creating greater safety for patients is the lack of implementation of policies and practices. Whilst the implementation gap can appear to be the result of insufficient resources, it is also a result of incomplete know-how and patient safety education. It is clear that safety training is still not embedded in clinical training programmes, nor is it a feature of patient information programmes. Ideas to enhance the relevance of safety training through non-verbal animations are a useful first step, but transforming the patient safety agenda requires research investment into what works best and where safety training produces evidence-based results. Education not only of the clinicians, but of the patients and the public also. All those working in health systems should have a basic understanding of Patient Safety.

Establishing cultures of safety

42. As the interventions and strategic approaches to safety become clearer, it is evident that there is a common thread whereby for safety to flourish a culture of safety is essential.

43. In addition to the policy and public momentum needed to drive improvement, culture is equally as important for safety innovations to land, take root and flourish. Part of establishing safe cultures is normalising ‘speaking up’, as has been achieved in other industries.

44. Culture is colloquially, but quite aptly, defined as “the way we do things around here” and shares close links with poor leadership and deeply engrained norms and habits. Facilitating positive culture needs strong and committed leadership, and can be scuppered by a command and control style. It is not only a product of leadership however; the working practice of clinical professionals can also drive culture. Often in healthcare, self-sacrifice and heroism is lauded as the most impressive way of managing crises. The long-term result of this is not only degradation of the role of teams, but intense physiological and psychological burnout, which erodes energy for innovation. On the other hand, tribalism in teams and departments also derails positive working cultures and stymies the ability of organisations to apply systems thinking. In both situations there is a lack of humility and an unsafe space for learning. Safety culture relies on staff being able to speak up, a culture of innovation and recognition that some innovations will fail. A balance needs to be struck between creating a positive culture of safety and the need for accountability.

45. The impediments to a creating culture of safety are more profound in LMIC or low resource settings: leadership is at a premium because it is not always sustained or prioritised given clinical needs; resource for teaching culture is scarce; there is chronic lack of infrastructure investment for logistics, management and digital, and the technical expertise to design, develop and deploy cultural innovations is limited. A

46. The health system cannot be asked to act alone in its endeavour to establish safe cultures. It is a shared objective, which patients suggest can be achieved with a greater degree of humility. Filling the communication and implementation gap requires digital innovation, and looking towards other industries. Eradicating the fear of failure may not be possible but opportunities to fail can be reduced through design improvements. It is also possible to clarify what is avoidable harm to reduce fears of blame. Equally training the trainer in mechanisms for safer communication so that these approaches proliferate across systems. Action for safer cultures have started with grass roots commitment to simple improvements, which has spread across wards, hospitals and countries. Campaigns like “Hello my name is” have achieved this as well as initiatives such as “10,000 Feet” for improving safety in operating theatres.

47. Low resource settings have an enormous challenge to deliver UHC and measure its success with patient-centric measures, and it is evident that impediments to safety culture are more profound in. However, high quality of care is not exclusive to high income settings, and with LMICS pushing the boundaries of innovation, there are a

number of opportunities to achieve improved culture in these settings.

48. The WHA Resolution commits the global community to create an environment unique to healthcare where “safety is in the air”.

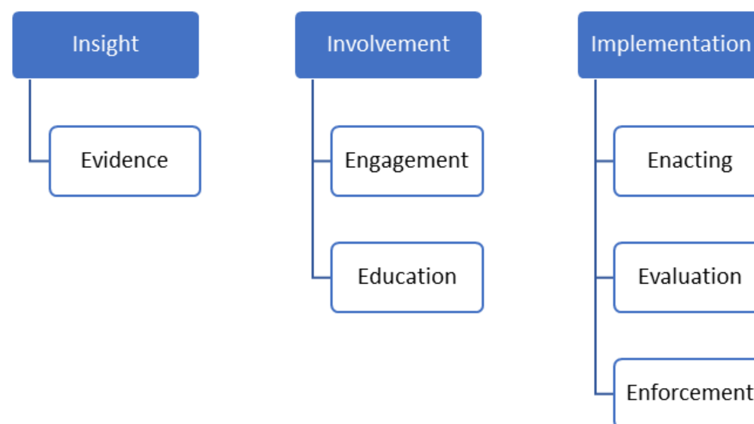
Global opportunities for safety

49. Success around patient safety will be when the dial starts to shift on morbidity and mortality metrics, when all staff feel safe to speak up and when, “the way we do things around here” is characterised foremost by safe, person-centred care.

50. The journey towards safer care is not without controversy: as one participant explained, “we are saying that ‘To err is human, but to err is unacceptable.’” Implementing global change for patient safety requires understanding the fallibility of human behaviour as well as the potential to maximise human capacity for personal, empathetic and safe care. Potentially fatal flaws within health systems need to be recognised and opportunities encouraged to design, innovate, regulate and co-produce them out.

51. Participants declared their commitment to act, especially to focus on the six E’s of Evidence; Engagement; Education; Enacting; Evaluation; and Enforcement, under the umbrella of a framework of 3 Is – Insight; Involvement and Implementation.

Figure 1. Framework for action



More specifically, the Forum members agreed the following actions:

Create national learning systems

Ensure meaningful collection and responses to patient feedback

Develop curricula for patient safety including curricula for investigations

Develop local and global portals for sharing ideas and best practice

Design systems to prevent harm with aligned priorities

Collect data about impact and evaluation

Harness existing digital innovations to improve patient safety.

Conclusion

Implementing the 2019 World Health Assembly Resolution is an opportunity to catalyse action towards improving global safety. The establishment of World Patient Safety Day on September 17 was unanimously supported.

Participants committed to pursue patient safety through their own institutions, health providers and governments; with a number of countries identifying how to build on their national policies to ensure safety was central to future policy.

The point of bringing safety out of a silo and into a global debate is that too often it is the dream to be the safest in the world; however, the aim is not to be the best in the world but for the world to be safer.

The Wilton Park High-Level Forum on Patient Safety set out an agenda for change that clarified the burden of harm, explored opportunities for global momentum and dissected the meaning of culture and how it can be optimised. Actions outlined by participants will be the cornerstones of local agendas to fulfil the global aim of safer universal healthcare.

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Wilton Park | June 2019

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