Our vision for an effective safety system

The Health Foundation

What does an effective system for safety improvement in the UK look like?

- **Measurement and monitoring**
  It is a system where it is made explicit that continuous improvement is the primary purpose of the use and publication of safety data; where safety measures strike the balance between past harm and future risk, and are sensitive to different settings and contexts; where a core set of national safety measures – including methods to collect the data – is agreed between the providers, commissioners, regulators and users of health care; and where safety data are regularly shared between oversight bodies, and the same information is not requested multiple times from providers of care.

- **Improvement and learning**
  It is a system where lessons from safety improvement work in one part of the system can be readily accessed and built on in another; where incidents and safety concerns are fully investigated at the appropriate level within the health care system; where the most serious safety concerns are routinely and rigorously investigated by an independent body; and where action to tackle systemic safety problems is coordinated at the regional or national level to include the providers, commissioners and regulators of care, and the manufacturers of health care products.

- **Engagement and culture**
  It is a system where people working in the NHS support and equip patients, their carers and families to take an active role in their own safety; where regional, national and professional training providers embed the science of safety and quality improvement in their programmes, to support the development of a critical mass of safety improvers; where providers continue to develop people's skills and knowledge to tackle the most pressing safety problems; and where commissioners and regulators give providers the space, time and support to develop their own improvement capability programmes.

- **Strategy and accountability**
  It is a system where there is a long-term strategy for safety improvement agreed between all stakeholders; a strategy that sets out the need for a just culture and clearly marks the boundaries between culpable breaches of care and unintended failures; where there is a compact between providers and regulators, which fosters a mature dialogue when safety problems are detected, allows opportunities for providers to proactively demonstrate the safety of their systems, and makes explicit that providers are, first and foremost, accountable to patients and the public.

See www.health.org.uk/publication/continuous-improvement-patient-safety