Service Definition

Lot 3: Cloud Support Services

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Introduction

Patient Safety Learning is a charity and independent voice for improving patient safety: helping health and social care organisations avoid preventable harm. Launched in 2018, our vision is to help create a world where patients are free from avoidable harm.

For a patient-safe future to become a reality, health and social care needs to design for safety, rather than focus on responding to harm, to be proactive in keeping patients safe. Ultimately, it must operate as an effective Safety Management System (SMS) with safety as a core purpose.

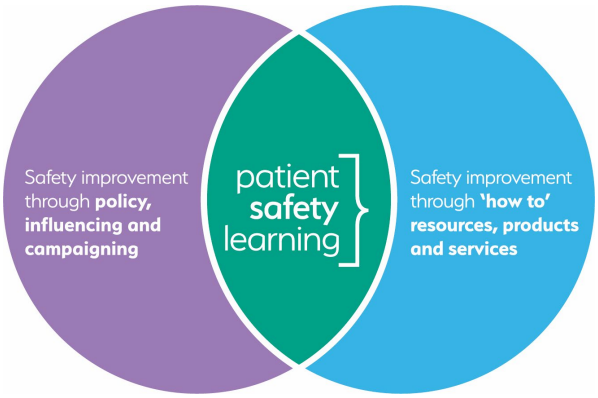
Who we are

Our mission and purpose is to transform safety in health and social care. We harness the knowledge, enthusiasm and commitment of organisations, professionals and patients to deliver system-wide change.

The charity operates as an independent, evidence-based organisation, registered with the Charity Commission (no. 1180689), working across the health and social care system including with NHS bodies, independent providers, professional and patient groups, industry, academics and researchers in the UK and internationally.

What we do

To meet these challenges, we focus on two areas of interconnected activity that are directly relevant to organisations procuring services via G-Cloud.



To achieve that, we are focused on two areas of activity: supporting safety improvement through policy development and campaigning; and creating and marketing a range of 'how to' resources, products and advisory services. Each is targeted at improving the understanding and practical delivery of 'what good looks like' in patient safety.

the hub

the hub is Patient Safety Learning's award-winning platform for shared learning. It is the world's largest knowledge base for patient safety offering a powerful combination of tools, resources, stories, ideas, case studies and good practice. Its Networks and

Communities of Interest give people a place to discuss, in confidence, patient safety concerns and how to address them.

'How-to' products and services
Over the years, Patient Safety Learning has developed a deep and comprehensive understanding of 'what good looks like' in patient safety. We have also applied that knowledge to the creation of a range of safety improvement resources, products and services that support the delivery of safer care.

Safety standards
Practical documentation and online tools that guide implementation of our unique patient safety Foundations, Aims & Standards

Training

Bespoke teaching courses and facilitated sessions designed to deepen an organisation's understanding and engagement with key patient safety topics

Expert advice

Customised commissions for specific patient safety projects that employ our specialist advisers

Our 'What Good Looks Like' standards and SMS approach

Our report, **A Blueprint for Action**, identified six evidence-based Foundations for safer care, each requiring action:

- Shared learning
- Leadership
- Professionalising patient safety
- Patient engagement
- Data and insight
- Culture.

One of our other reports, **Mind the Implementation Gap**, highlighted the difference between what we know improves patient safety and what is done in practice. There are four common underlying themes:

- Absence of a systemic and joined-up approach to safety
- Poor systems for sharing learning and acting on that learning
- Lack of system oversight, monitoring, and evaluation
- Unclear patient safety leadership.

Combining this learning with that from 'A Blueprint for Action', we developed a seventh Foundation focusing on the Delivery of Safe Services: how staff are supported and deployed for system reliability; effective risk management; the design and application of human factors; and continuous quality improvement.

These seven Foundations are the backbone of a core element of Patient Safety Learning's offer, its world-first, evidence-based patient safety Standards and "What Good Looks Like" framework, derived from over 20 years of research, national policy (including NHS England's Patient Safety Strategy) and the WHO Global Patient Safety Action Plan. These standards describe the outcomes, behaviours and actions needed for organisations to become effective learning systems operating a robust Safety Management System, supporting Boards, leaders and frontline teams to define safety aims, prioritise improvement and provide assurance to regulators, commissioners and the public

How we support organisations

Using this standards-based framework, Patient Safety Learning provides a range of tailored support, including diagnostic assessments, facilitation, design of improvement programmes, and advisory input to governance and strategy, all aligned with local and national requirements. This helps Trusts, ICBs and other providers to benchmark current performance, identify gaps, co-design practical improvement roadmaps and embed safer ways of working, ultimately leading to more consistent high-quality care, stronger safety culture and better use of resources.

Reach, networks and partnerships

Through *the hub* and its wider programmes, Patient Safety Learning has built a large, international community of members and partners spanning clinicians, managers, patients, researchers, regulators and industry, supporting cross-sector collaboration and rapid dissemination of learning. The charity's Partners Programme connects healthcare organisations and businesses with Patient Safety Learning's expertise and networks, enabling co-development of tools, insights and services that can be scaled and shared across systems via digital platforms such as those procured through G-Cloud.

Services

Patient Safety Learning offers a suite of integrated, evidence-based services that help health and care organisations design, implement and sustain "What Good Looks Like" in patient safety, underpinned by a robust Safety Management System and practical standards, tools and expert support. These services range from access to the charity's standards and guidance, through cloud-based self-assessment tools, to tailored consultancy, training and "critical friend" support, enabling Boards, leaders and teams to understand their current position, prioritise improvement and deliver safer, more reliable care.

Self-assessment against our patient safety standards

Organisations are legally required to take 'all reasonable and practical steps' to improve safety; but 11,000 avoidable deaths and over 400,000 serious incidents of patient harm each year evidence a failure in this ambition.

The CQC has assessed that, in 2020 (before the pandemic), the proportion of NHS Trusts' safety ratings were: 1% excellent; 63% good; 34% requiring improvement; and 2% inadequate. One of the primary reasons for such shocking figures is that

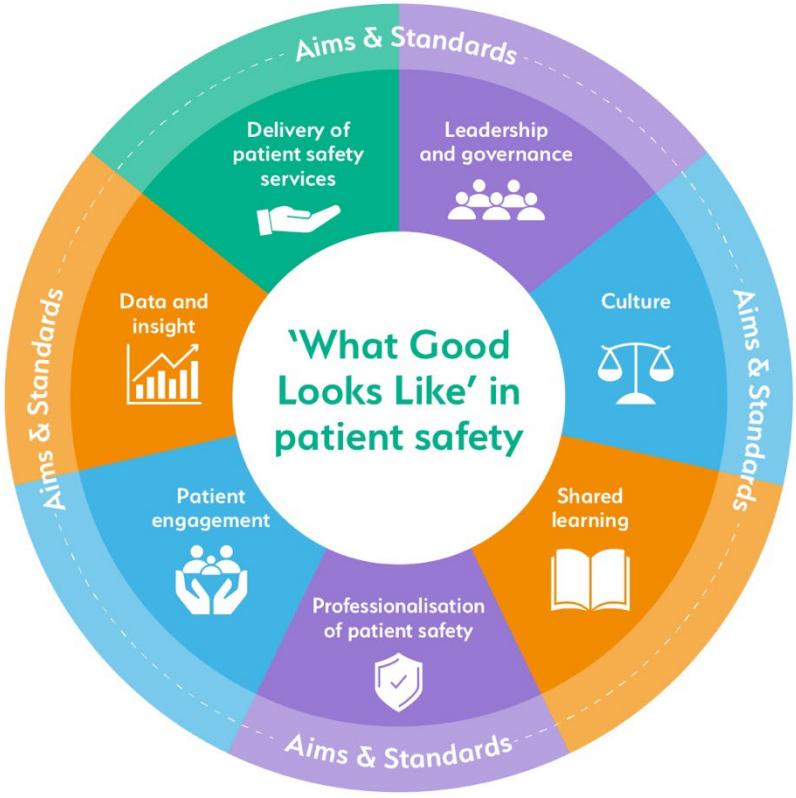
organisations don't have standards for patient safety in the way that they do for other safety issues. Those that they do have are insufficient and inconsistent. Patient Safety Learning believes that all health and social care organisations must have access to comprehensive patient safety standards that they can adopt and implement to meet their legal and moral obligations.

In response to this, Patient Safety Learning has designed a set of unique patient safety standards and support tools that can help organisations not only establish clearly defined safety aims and goals, but also demonstrate their achievement.

These Standards are based on 20 years of research, as well as learning from inquiries, policy and good practice from healthcare, both in the UK and internationally.

We have built on insight and learning from human factors and ergonomics, widely applied in other safety critical industries. We have supplemented this with our own research, working in partnership with organisational patient safety specialists and practitioners to ensure that our Standards are quality assured, with 'real world'

What the standards cover



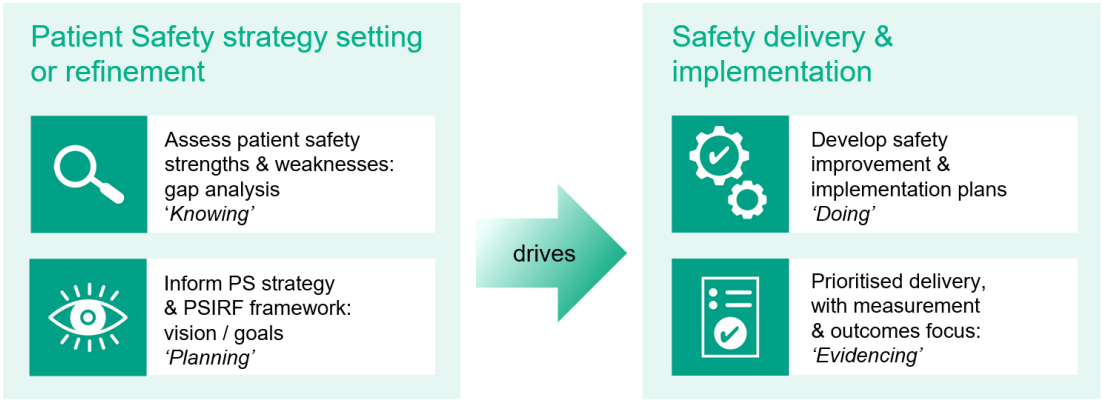
Underpinning each Foundation / Aim, there are a series of clearly defined Standards that explain what an organisation must do to deliver against the specific requirements of each individual Foundation / Aim.

In turn, for each Standard, there are details of evidence-based outputs, outcomes and behaviours required to enable an organisation to demonstrate achievement against those Standards. In total, there are 144 identified Standards.

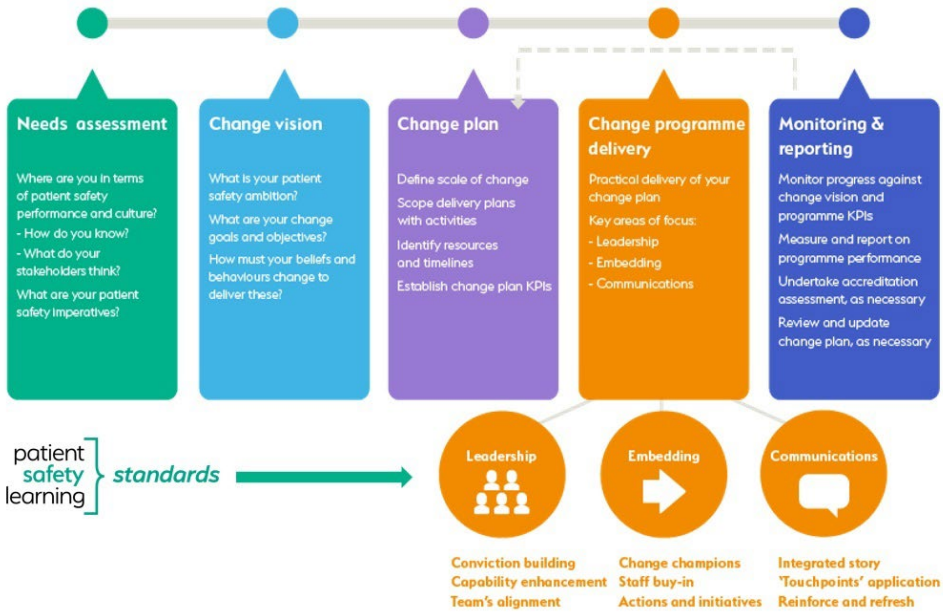
These represent the core for any organisational safety improvement strategy and delivery plan.

Our 'What Good Looks Like' products and services are practical and outcomes focused. They can be accessed and used in various ways depending upon where an organisation is on its patient safety journey and in relation to its ambitions.

At one end of the spectrum, they can help with patient safety strategy setting and / or refinement to an existing strategy. At the other, in support of safety delivery and implementation.



Or they can fulfil a broader role, underpinning and directing a systems-wide change framework or Safety Management System (SMS), either integrated into a programme that is already underway or as a 'ground-up' approach.



This can include strengthening Board / senior leadership patient safety awareness, understanding and commitment; educating and training all levels of staff in the delivery of safer care; improving internal and external communications and engagement around patient safety.

Client experience demonstrates that working in partnership with Patient Safety Learning and supported by our 'What Good Looks Like' products and services can contribute significantly to success. (Click **here** for the GOSH case study.)

The self-assessment patient safety standards tool and associated materials can be accessed via the Cloud for an annual subscription. In addition to the subscription, tailored consulting services can be provided to support organisations on their journey towards improved patient safety.

Consultancy to support improved patient safety

Organisations have already used these standards to provide an evidence-based means against which to review their operational patient safety delivery plans and help create an organisation-wide safety transformation programme.

Consultancy work to plan and deliver such a programme could include the following deliverables:

- ***Creation of an 'Organisational 'Snapshot':*** A simple and easily implemented diagnostic based on our patient safety Foundations and Aims and cross-referenced to our full Standards. Using a mix of one-on-one interviews and workshops with a small number of selected individuals across an organisation or particular team, our 'Snapshot' can quickly identify:

  - where their focus should be on patient safety improvement
  - how to create a strategic plan
  - how to set goals
  - if a more detailed assessment against our Standards needs to be undertaken.

  The key benefits of such an approach are that it enables an organisation to begin the assessment process in a cost, time and resource efficient way, establishing a high-level baseline from which to agree future steps of work as needs demand and circumstances permit.

Do you have the foundations for safer care?	What else should you consider?	Can you be certain?
Do you have the right leadership and governance to deliver safe care?	Not just commitment, strategies & processes, but behaviours too.	*How do you know?*
Does your organisational culture promote and support patient and staff safety?	Or is your ambition undermined by blame & fear?	*Would your staff agree?*
Do you share and apply learning across your organisation?	Not just learning from incidents of unsafe care, but how to apply good practice to mitigate risk.	*Has it changed things?*
Are you professionalising patient safety?	Are your expert staff using 'What Good Looks Like' to design & deliver safer care?	*If not, why not?*
Are your patients and their families actively engaged in safety?	Are patents & their families involved in shared decision-making and do their insights inform the design & delivery of improvements, when things go wrong?	*Have you asked whether they feel encouraged to do this?*
Do you effectively measure and monitor your safety performance?	Is there sufficient emphasis on proactive risk assessment & quality improvement, rather than focusing overly on retrospective learning from harm.	*Do you feel confident in your ability to do so?*
Are your patient safety services safety?	Do you have the right conditions & systems to enable your staff to deliver safe care?	*How do you assure yourselves?*

- An assessment of the strengths and weaknesses of the organisation's current patient safety situation and needs. Specifically, this could include reviews of and advice on:
    - Effective leadership and governance for patient safety: Executive, Non-Executive, clinical and managerial roles with responsibility for safety and quality including team and personal development programmes, coaching and mentoring
    - How to build an open and fair culture for patient safety building on principles of psychological safety and encouraging a 'no-blame' approach to speaking up for safety
    - How to ensure actionable earning and improvement, especially from incidents, complaints & staff feedback
    - Engaging with, listening to and learning from Patient and staff, the patient safety frontline
    - Patient safety capacity and capability across the organisation including creating an operating model with roles of Patient Safety Specialists, Patient Safety Managers, Governance and Risk leads
    - Data for patient safety including metrics, trends and risk vulnerabilities
    - Effective engagement and response to Coroners Inquests, external reviews and investigations
    - Support to engaging Royal Colleges' Invited Reviews
    - Specialist assessments of the effectiveness of Trust's Infection Prevention Control

- Refinements to the organisation's operational patient safety delivery plans with an emphasis on:
    - Governance, decision-making and resourcing
    - Prioritisation of objectives and imperatives
    - Clear definition of deliverables
    - A need for stronger success measurement (outcomes and impact focused)
    - Staff and patient / family engagement, buy-in and communication.

- Board development to:
    - Build understanding and commitment to patient safety
    - Identify how to strengthen the organisation's culture
    - Define leadership and senior management roles and relationships in creating 'conditions for success'
    - Agree a decision-making checklist to support safety transformation, along with an outcomes and measurement framework.

- Patient safety improvement implementation planning supported by:
    - The creation of a suitable governance structure
    - Enhanced leadership capacity via new roles where applicable
    - Refinements in central patient safety and quality improvement capacity and expertise
    - Refined patient safety roles and resources in Clinical Directorates
    - A new integrated delivery programme
    - Improved staff / patient engagement and communications.

Training, Development and Mentoring in Patient Safety and Human Factors

Patient Safety Learning provides bespoke training, development and mentoring to build practical skills and confidence in patient safety and human factors, enabling leaders and frontline teams to put "What Good Looks Like" into everyday practice. These offerings draw on the charity's evidence-based Standards and Safety Management System approach, combining real-world experience, contemporary safety science and local context to support safer care, stronger safety culture and better experiences for patients and staff.

Training, development and mentoring programmes are tailored to the needs of each organisation and can be delivered through one-to-one sessions, small groups or larger workshops, either virtually or in person. Content typically covers:

- foundations of patient safety
- systems thinking and human factors aligned to NHS PSIRF framework
- Operational delivery framework for patient safety including governance and roles
- the practical application of Patient Safety Learning's Standards, helping teams translate strategy into day-to-day behaviours and decisions

Sessions can be aligned with existing frameworks (such as local patient safety strategies, PSIRF implementation or quality improvement priorities) and are designed to complement internal education, providing an external "critical friend" perspective that supports sustained capability building rather than one-off training events.

Specialised PSIRF training

This training offering focuses on equipping leaders, patient safety leaders and specialists, investigators and frontline teams to apply NHS England's Patient Safety Incident Response Framework (PSIRF) confidently and consistently in day-to-day practice. It is designed to move organisations beyond compliance towards using PSIRF as a key component of their wider Safety Management System, strengthening learning from patient safety incidents, improving culture and delivering safer care.

The training programmes typically combine interactive workshops, case-based learning and practical tools that are tailored to local context and maturity. Core content covers:

- Understanding the purpose, principles and key requirements of PSIRF, including its four core aims (compassionate engagement, system-based approaches, proportionate responses and supportive oversight) and how it differs in concept and application from the former Serious Incident Framework.
- Developing and reviewing a robust Patient Safety Incident Response Policy and Patient Safety Incident Response Plan (PSIRP), including how to use local data and stakeholder insight to prioritise risks, choose appropriate response methods and keep plans under regular review.
- Applying a range of system-based approaches to learning (for example, structured review tools and human-factors-informed methods), with guided practice on real or simulated incidents to build capability and confidence. This focuses on in-depth understanding and application of safety science in incident reviews, investigations and the development of service improvements including safety science tools such as
    - SEIPs
    - Thematic Analysis
    - AAR
- Embedding compassionate engagement with patients, families and staff affected by incidents, aligned with national guidance on involvement and support.
- Strengthening governance and oversight so Boards and senior leaders can assure themselves that PSIRF is functioning effectively and driving improvement, not just generating reports.

Depending on need, the offer can be extended to include mentoring and "critical friend" support for those leading PSIRF implementation, such as co-design of local training cascades, review of draft PSIRPs and policies, and periodic reflective sessions to troubleshoot challenges and share learning as the framework becomes embedded.

Facilitated PSIRP improvement round tables

This offering brings together patient safety leaders from multiple NHS (or private sector) organisations in a facilitated learning environment to review, compare and refine their Patient Safety Incident Response Plans (PSIRPs), strengthening alignment with PSIRF principles while enabling shared learning across the system. The aim is to improve the quality, clarity and usability of PSIRPs, support more consistent implementation of PSIRF, and build a collaborative network of leaders who can sustain improvements beyond the round table events.

Within this service offering, Patient Safety Learning designs and facilitates a structured series of cross-organisational workshops (virtual or in-person) where participants:

- Build a shared understanding of PSIRP purpose and required content (including describing the local incident profile, response methods, rationale and review approach) using examples of good practice and relevant national guidance.
- Share and critically appraise their draft or live PSIRPs in a safe, non-judgemental space, exploring differences in approach (for example incident prioritisation, learning response methods and review cycles) and identifying opportunities to strengthen proportionality, system-based learning and compassionate engagement.
- Work through structured exercises to test how their PSIRPs would function in practice across single- and multi-organisation incidents, including roles, governance, escalation, cross-system learning and alignment with patient safety incident response standards.
- Develop clear improvement actions for each organisation's PSIRP (and associated policies, templates and processes), supported by expert "critical friend" feedback from the charity and peer input from other participants.

Between sessions, participants can access optional mentoring and light-touch one-to-one support to refine their documents and prepare for subsequent workshops, helping to maintain momentum and embed changes locally. The series concludes with a consolidation session where organisations share their updated PSIRPs, reflect on impact and potentially agree to ongoing collaboration (via the hub) to sustain shared learning and improvement.

Facilitated systemic patient safety improvements

One significant gap in the current patient safety landscape in England is the lack of structured systematic approaches to learning and solution development. In the absence of this, insights from good practice and investigation into patient safety incidents tend to be retained solely within individual organisations.

The proposed structural changes in the NHS do not address the ongoing patient safety "implementation gap". They also do not tackle the absence of systematic approaches to sharing learning about avoidable harm, the inadequacy of joined up approaches and user-centred design in solution development.

Patient Safety Learning has recognised and responded to the need improvement action in the NHS at local and national levels to ensure that causes and contributory factors of avoidable harm are not just better understood but acted upon to prevent future tragedies.

In the absence of a national programme taking a safety science and system-based approach to improvement, one of the Patient Safety Networks has launched a project that has brought together paediatricians, nurses, pharmacists, nutritionists, specialist parenteral nutrition teams, and other safety experts from the NHS in England, to explore and propose improvements in paediatric patient safety across with the aim of engaging widely with stakeholders after the initial workshop stages.

Under the project management of Patient Safety Learning and a NHS Trust, we are working to improve parenteral nutrition in neonates and develop this multi-disciplinary and multi-professional collaboration into a future model for safety solution development and delivery.

Patient Safety Learning offers its insights, methodology and expertise to support the understanding of systemic cause of avoidable harm and to address them through facilitation of system improvement through engagement with safety science and human factors methods.