Session Programme

	Presenter
Introduction to the session	Urban Nylén
How to develop, implement and monitor national action plans for safer healthcare	**Olivia Wigzell**
Content of the action plan – focus areas for safety and support for implementation	Axel Ros
Reflections from Safer Healthcare – Strategies for the Real World	Charles Vincent
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Socialstyrelsen
THE NATIONAL BOARD OF HEALTH AND WELFARE

How to develop, implement and monitor national action plans for safer healthcare

Olivia Wigzell, General Director
The National Board of Health and Welfare

Gothenburg 20 June 2022

The National Board of Health and Welfare is a government agency

Working to ensure good and high-quality health and social care for all in Sweden

Socialstyrelsen
THE NATIONAL BOARD OF HEALTH AND WELFARE

High quality health and social care is based on knowledge. This is our mission.

Population:
10,5 M

Decentralized healthcare – working **together** for the highest attainable standard of health

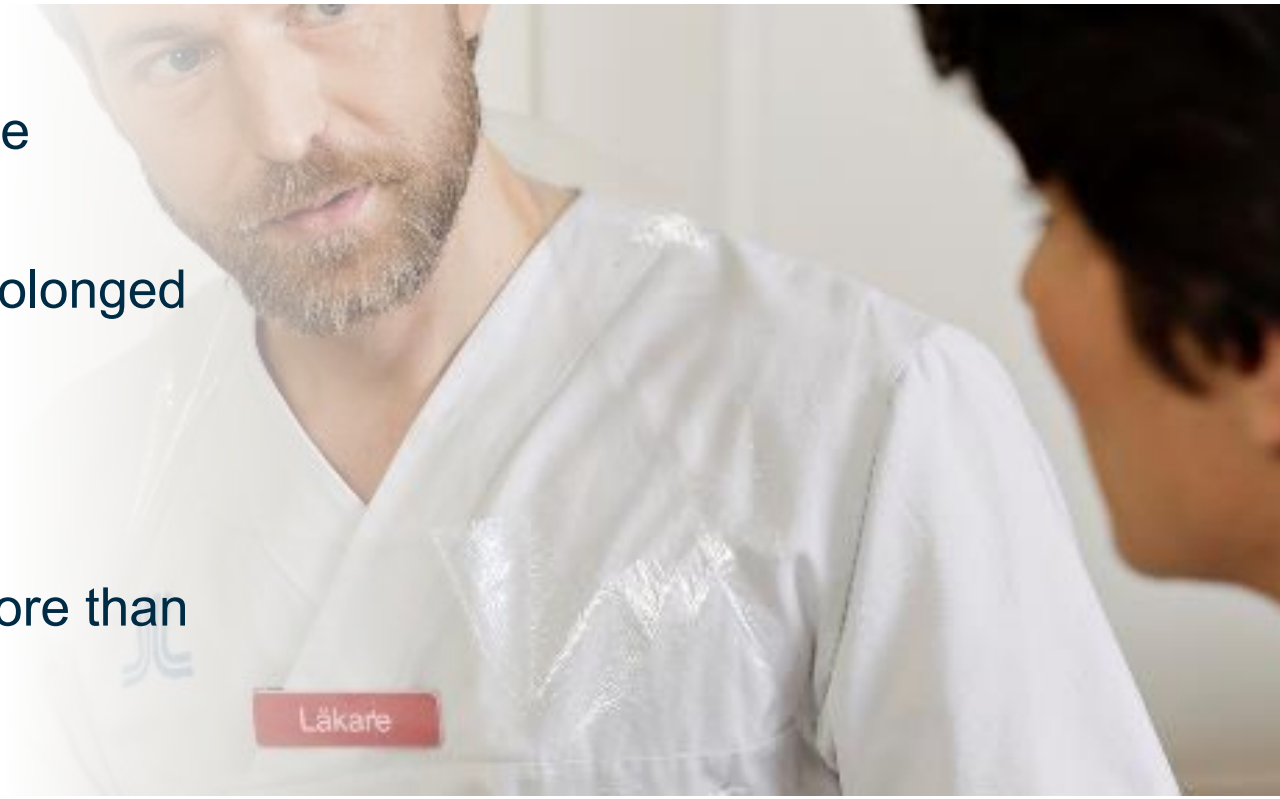
National level
Legislation, monitoring and mainly university education.
Support and supervision through **government agencies** and authorities.

Regions (21)
Independent by constitution. Main responsibility for **healthcare**.

Municipalities (290)
Primary health care for mainly **elderly and people with disabilities**.

Sweden calls for increased national and coordinated efforts to support patient safety

- **Approximately 1 in 10 patients** experience avoidable harm every year
- For **50 000 patients** these events cause prolonged hospitalization
- **Between 2 000 and 2 600 patients** suffer permanent harm
- Avoidable harm is a contributing factor in more than **1 000 deaths**



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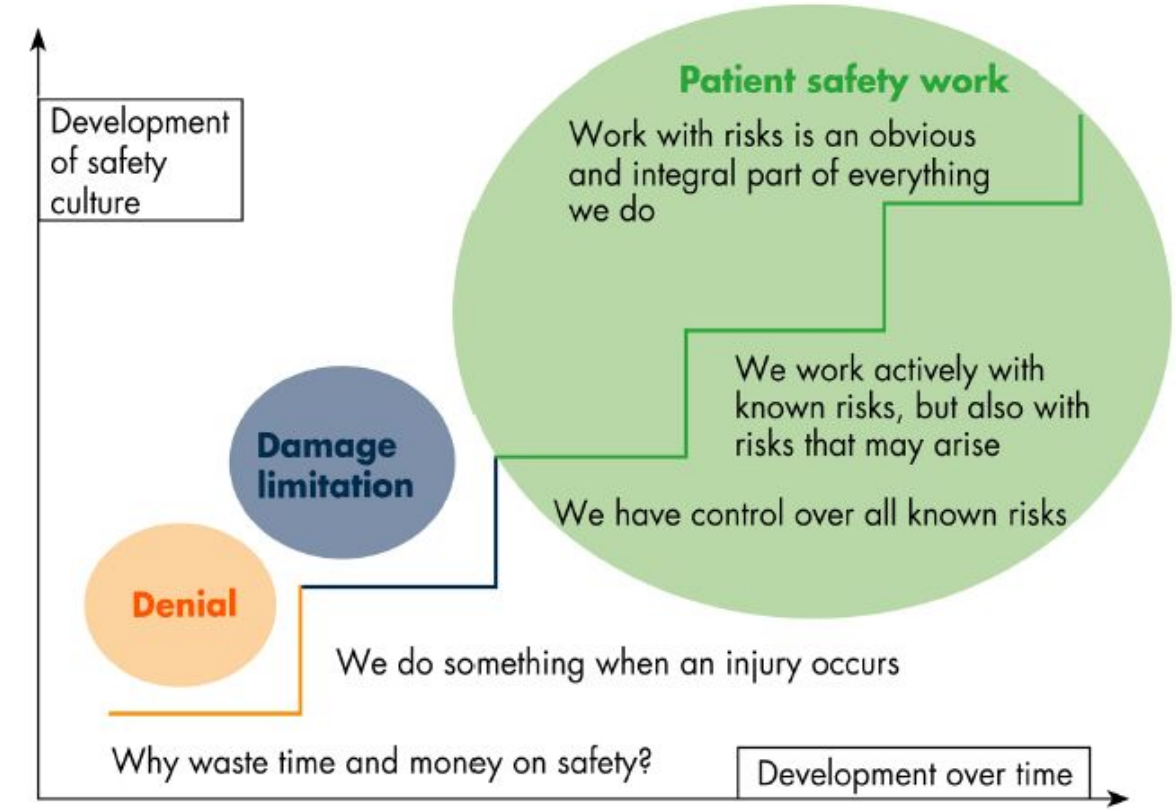
The road to working actively with preventive patient safety

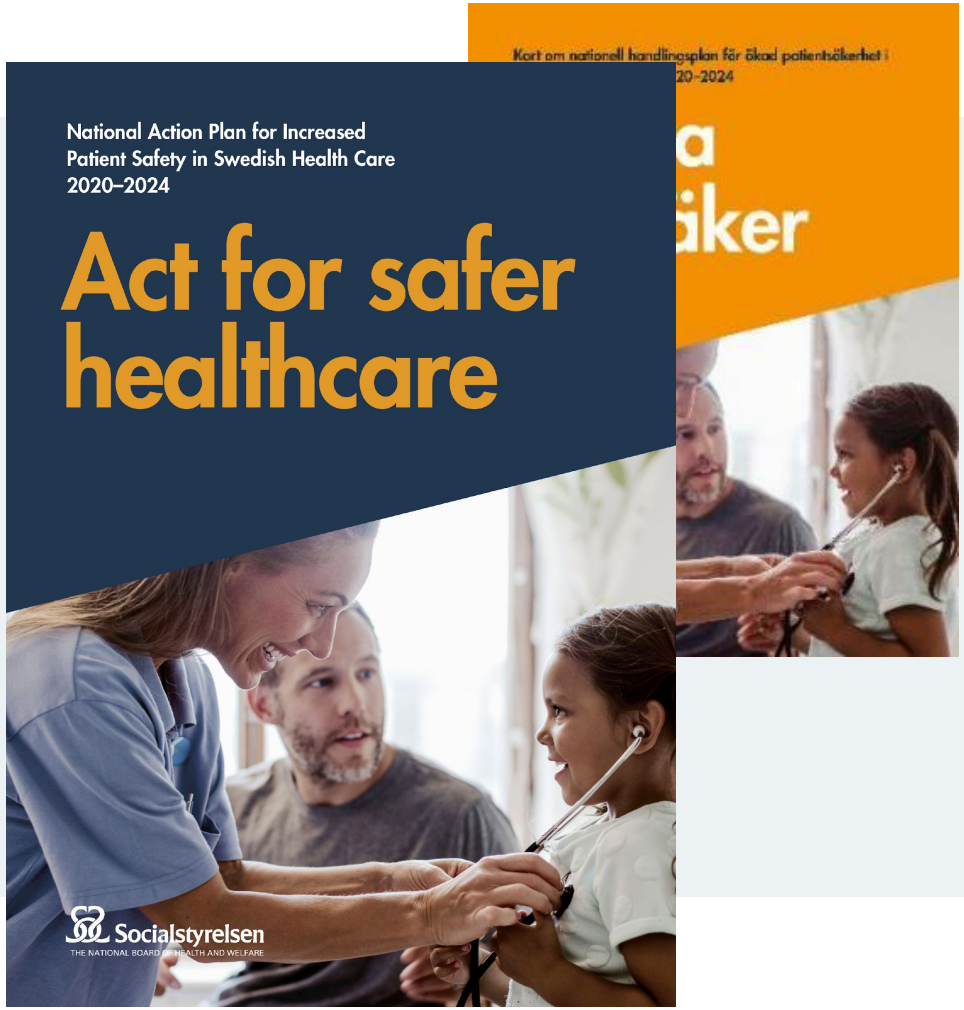


Freely after: D Parker, NPSA, Managing risk in healthcare: understanding your safety culture using the Manchester Patient Safety Framework (MaPSaF), Journal of Nursing Management, 2009, 17.

Sweden’s first action plan for increased patient safety

In 2018, the National Board of Health and Welfare was commissioned to develop a national action plan for increased patient safety. It

- contains goals, focus areas, national interventions and plans for evaluation,
- targets decision makers,
- supports municipalities and regions in the development of action plans,
- coordinates and supports work on patient safety across the country,
- aims to enhance regional and municipal patient safety initiatives including key principles, priorities, goals and measures for increased patient safety.

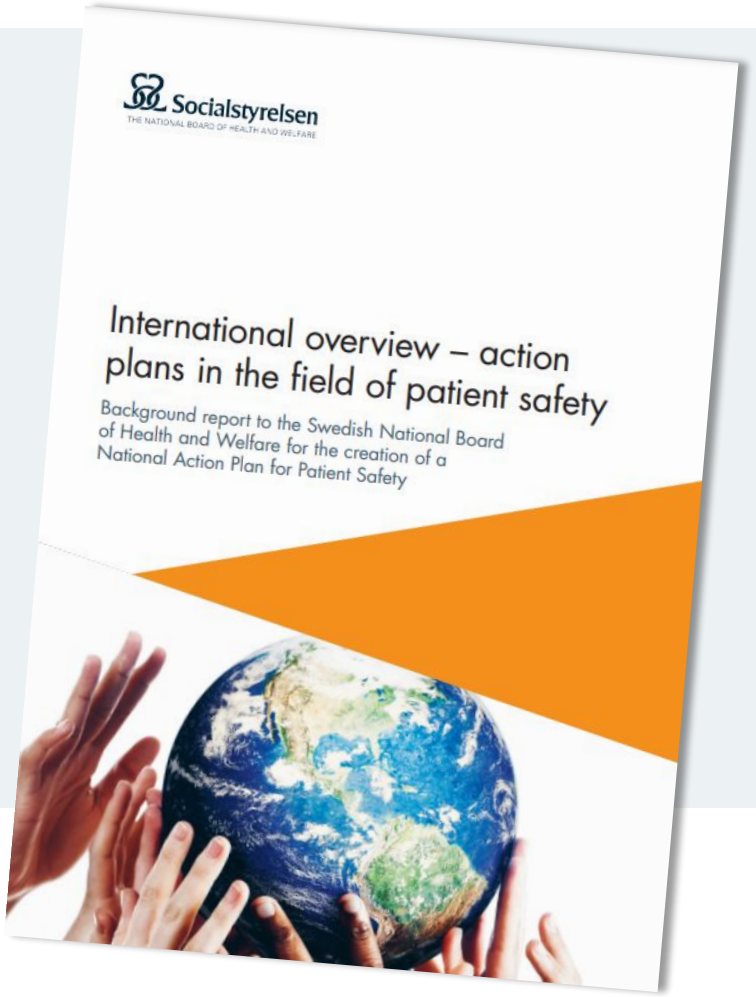


The National Action Plan was developed in broad cooperation

Multiple **stakeholders**

An international overview – action plans in the field of patient safety was a good starting point

- One overall reflection on the international analysis is that **context has significant meaning** on the structure and impact of patient safety work.
- **A national action plan alone cannot have an impact** on the effectiveness of patient safety work.
- The context is essential in order to **create the conditions for solid and sustainable management** of patient safety work.



Good and safe care – whenever and wherever
- that's our vision

The overall goal:
No patient should have to suffer from avoidable harm

The vision and goal are formulated to emphasize a broad approach to the safety initiatives which include:

- Both the **presence of safety** and the **absence of harm**
- To move **away from focus on past harm**
- **All areas of activity in all healthcare situations**

Harnessing the Power of the Feedback Loop: creating motivation to increase patient safety

Thank You All!

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Act
for Safer Health Care

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National coordination of regional healthcare patient safety efforts in Sweden

Part of the national system for knowledge-driven management within Swedish healthcare

Axel Ros

Chief Medical Officer/Patient Safety lead
Region Jönköping County, Sweden

Nationellt system
för kunskapsstyrning
Hälso- och sjukvård
SVERIGES REGIONER I SAMVERKAN

Theoretical context that has influenced the action plan

Learning from everything that happens, not just the things that go wrong

Safety as reliability in healthcare processes

Safety as risk management over time

Ready for that which can be anticipated, and for that which cannot

In order to work towards the vision and the overall goal, four basic conditions are highlighted:

- Committed management and clear governance
- A good safety culture
- Adequate knowledge and competencies
- The patient as co-creator (co-captain)

The Action Plan contains five priority focus areas

- Increase knowledge of avoidable harm
- Reliable and safe systems and processes
- Safe care here and now
- Strengthen analysis, learning and development
- Increase risk awareness and preparedness

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Within each focus area:

- an introductory text
- what the focus area is aimed at
- national actions (27) for improvement, with assigned actors/stakeholders
- examples of what healthcare providers need to do

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Follow-up

- A plan
- A need for development of indicators

Reinforcing systematic patient safety initiatives across Sweden

The overall purpose of the Action Plan is to

- influence safety development at **all levels of healthcare**
- enhance **regional and municipal patient safety initiatives**

The national system for knowledge-driven management within Swedish healthcare

A collaboration between healthcare regions for a knowledge-based, equal and resource-efficient healthcare

National program groups

National collaboration groups supports the work in the national program groups with expertise in:

-

- Patient safety

-

Nationellt system
för kunskapsstyrning
Hälso- och sjukvård
SVERIGES REGIONER I SAMVERKAN

National collaboration group Patient safety

Tasks:

1. To support work within the national program groups with patient safety knowledge
2. To coordinate patient safety work between the healthcare regions

   For example in implementation of the National Action Plan for Increased Patient Safety

”The tool”

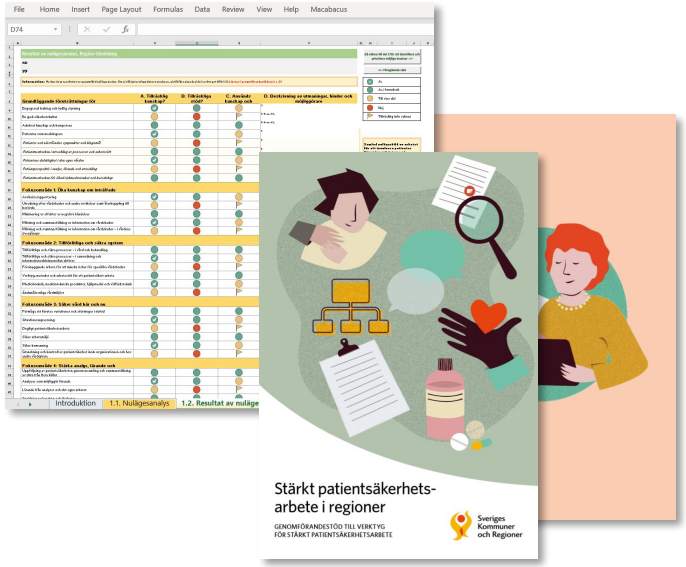
The tool

to support improved patient safety work in the regions

Aimed at supporting

- the implementation of the national action plan
- improvement of patient safety at the regional and local level

Developed in cooperation between
- National collaboration group Patient safety
- National Board of Health and Welfare
- Swedish association of local authorities and regions



Nationellt system för kunskapsstyrning Hälso- och sjukvård
SVERIGES REGIONER I SAMVERKAN

The tool

Supports an analysis of the gap where you want to be and where you are, through:

- A set of four questions in 33 themes related to the basic conditions and focus areas defined in the national action plan

A	Does management and front line staff have knowledge of what is important in this theme?
B	Does management and front line staff have the support needed to act in according to best practice?
C	Is the use of knowledge and support good enough and appropriate?
D	Give a short description of your challenges.

- A summary of all answers
- An aid to prioritize between areas identified for improvement
- A support for documentation of actions to take

Thank You!

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Charles Vincent

Professor of Psychology, University of Oxford

Reflections I

- Conceptual clarity
- Strengthening the foundations
    - Building on what has gone before
    - Focus on reliability
    - Creating the conditions for safety
    - Emphasis on the working environment
- Whole system approach
    - Vertical and horizontal integration
- Ambitious programme of projects
    - But nested within broader programme

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The Health Foundation Inspiring Improvement

Reflections 2

- Risk management over time
  - Safety along the patient journey
  - Seeing safety through the patient's eyes
  - Emerging risks, such as coordination of care
  - Safety in the home
- Past, present and future
  - Safety is created moment to moment in clinical teams and by managers
- Learning from everything that happens
  - The value of studying errors and harm
  - A window on the system
  - The need to go beyond to study the work process and environment

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The Health Foundation Inspiring Improvement

Thank You!

Charles Vincent charles.vincent@psy.ox.ac.uk

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The Health Foundation Inspiring Improvement

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TOGETHER

Investment in increased patient safety

Elmar Keppel
Lena Hagman

Region Kalmar län
BORGHOLMS KOMMUN
Emmaboda kommun
HÖGSBY KOMMUN
HULTSFREDS KOMMUN
Kalmar kommun
Mörbylånga kommun
NYBRO KOMMUN
Oskarshamns kommun
Torsås kommun
Vimmerby kommun
VÄSTERVIKS KOMMUN
MÖNSTERÅS

National Action Plan for Increased Patient Safety 2020–2024

The action plan is designed to be used by municipalities and regions that can establish principles, priorities and objectives for their patient safety work, through their own action plans

The overall goal:
No patient should have to suffer from adverse events

For whom we are there for

Region Kalmar län
BORGHOLMS KOMMUN
Emmaboda kommun
HÖGSBY KOMMUN
HULTSFREDS KOMMUN
Kalmar kommun
Mörbylånga kommun
NYBRO KOMMUN
Oskarshamns kommun
Torsås kommun
Vimmerby kommun
VÄSTERVIKS KOMMUN
MÖNSTERÅS

- Mapping
- Analysis of mapping
- Gap-analysis

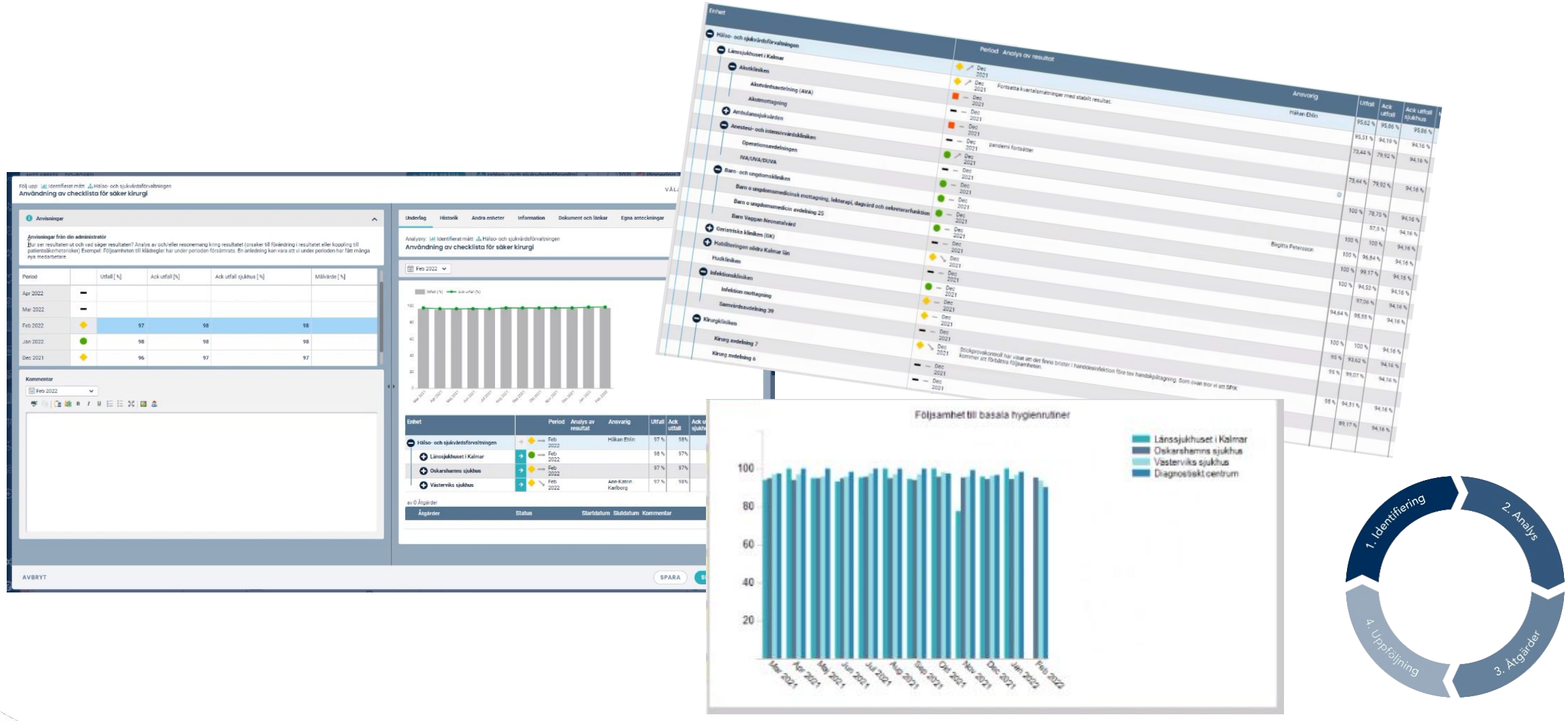
What has been done so far in Kalmar County?

Mapping of regions goals an activities related to quality and patient safety
– National action plan as base

Complexity and Diversity

What?
Who?
How?
- Consensus

Mapping



Goal Management System

- Mapping
- Analys of mapping
- Gap-analysis
- Areas of priority
- Regional Action Plan
- 4 teams, one for every area of priority

What has been done so far in Kalmar County?

County-wide main team

Team 1

Systems and processes

Team 2

Knowledge and learning

Team 3

Inhabitants as co-creators

Work in progress

Region Kalmar län
BORGHOLMS KOMMUN
Emmaboda kommun
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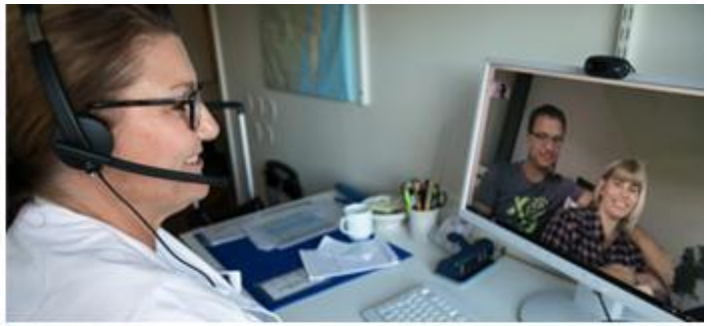

For whom we are there for

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NYBRO KOMMUN

Oskarshamns kommun

Torsås kommun

Vimmerby kommun

VÄSTERVIKS KOMMUN

MÖNSTERÅS

Together

Region Kalmar län
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Oskarshamns kommun
Torsås kommun
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VÄSTERVIKS KOMMUN
MÖNSTERÅS

Thanks!

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Round-table discussion 1

How can we get action from national action plans?

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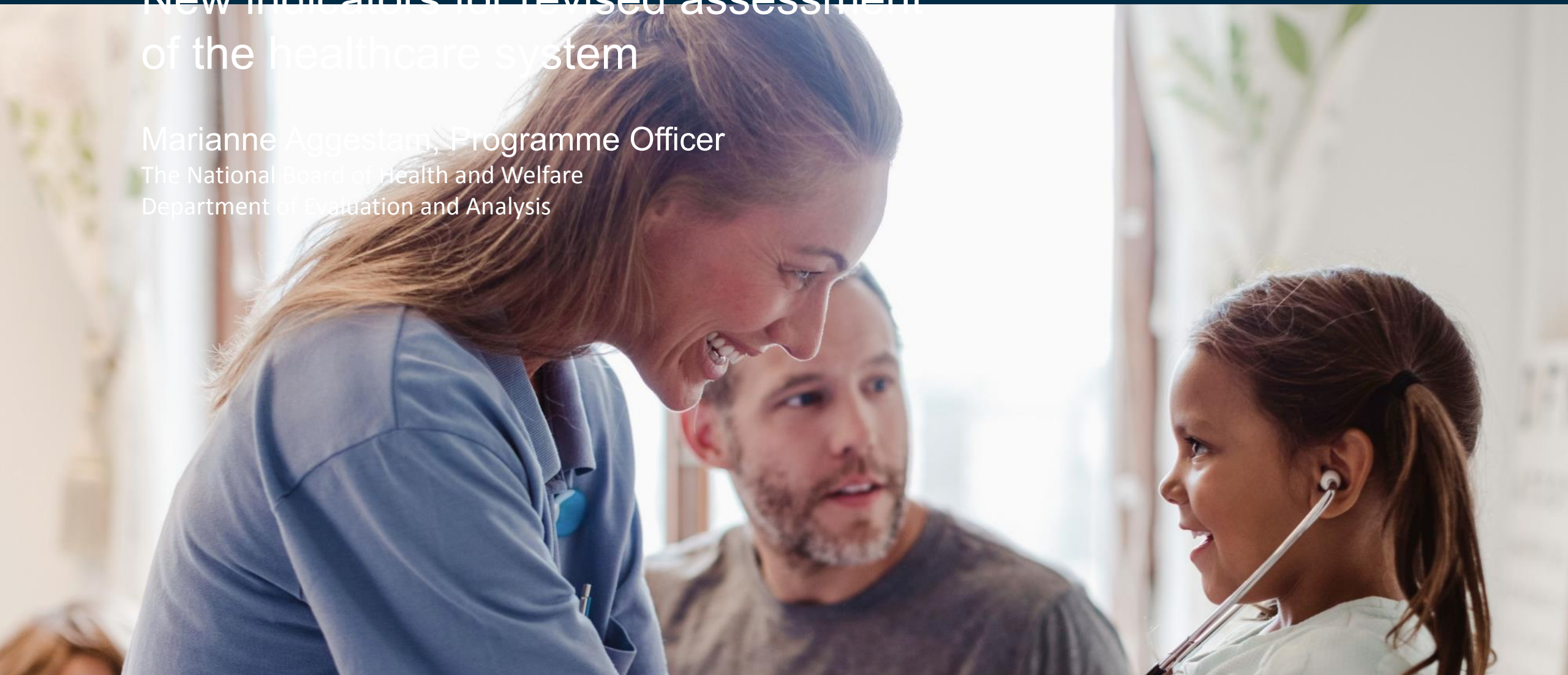
Patient safety performance

New indicators for revised assessment of the healthcare system

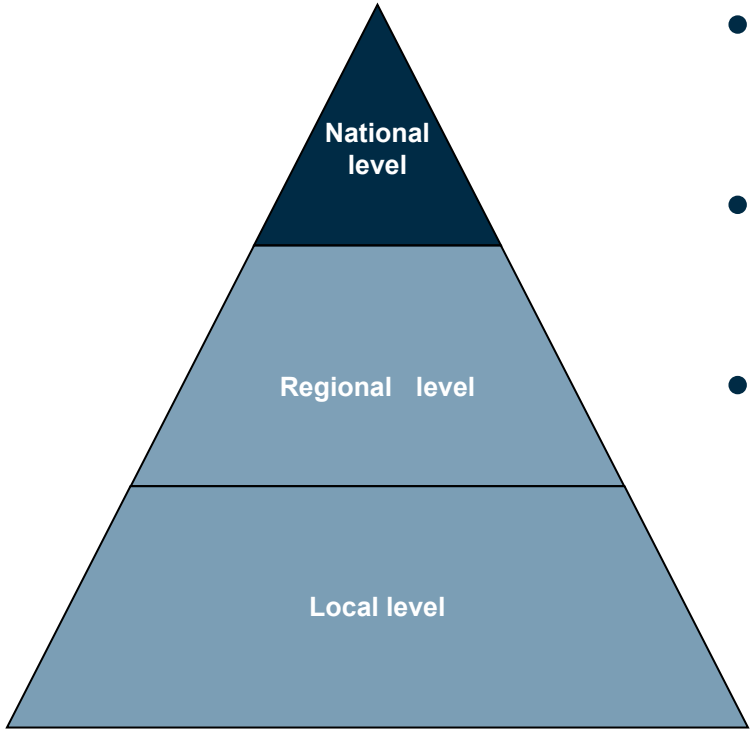
Marianne Aggestam, Programme Officer
The National Board of Health and Welfare
Department of Evaluation and Analysis



Why report and monitor safety?

Current situation and development

A common ground for dialogue



- Politicians and stakeholders want an update and a national context.
- Citizens and patients' interest in quality and safety.
- Managers and professionals in the organisations as well as researchers and developers need to compare and analys healthcare outcomes in a common context.

So far - lots of data in Swedish healthcare

Adverse events and harm

Data sources

Incentive for change

Cooperation and shared ownership

The National Board of Health and Welfare

- **National Health Data Registers**
  Cancer, Medical Birth, Patient Register, Prescribed Drugs, Cause of death, Health care practitioners, Municipal Health and Medical Act, Care for the Elderly and the Disabled, Dental Health, DRG-system (Nord-DRG-se)

National Quality Registers

- **National quality registry**
  Individualized data about medical interventions and outcomes after treatment. PREM and PROM.
  About 100 registers are nationally funded.

Other data sources

- **Other data sources**
  Case-costing data – national database, Waiting time database, National surveys of patient experiences (PREM).
  The Stakeholders own data sources
  And more…..

What is important ahead?

To promote progression

A proactive mindset

The national action plan

- **A framework for monitoring safety** according to the national action plan
- **New additional indicators** a balanced view of **basic conditions** and **priority focus areas**
- Indicators that give **incentive for change**
- **Cooperation** and **shared ownership** in development and monitoring

A new framework for monitoring safety

- Has healthcare been safe?
- Is healthcare safe here and now?
- Is there risk awareness and preparedness?

Has healthcare been safe?

Focus area 1

- Events with negative effect for the patient, patient's experiences of adverse events
- Staff's perception and experience of support and consequences regarding adverse events

Is healthcare safe here and now?

Focus areas 2 and 3

- To what extent recommended processes are applied for care to be knowledge-based and safe
- Ability to identify and manage short term risks at an early stage
- Patients experiences from care and involvement in planning and design of their own care

Are there risk awareness and preparedness?

Focus areas 4 and 5

- Decisive factors for improvement of knowledge, overview of data, analysis and learning
- Identification of long term risks, signs of preparedness and resilience for health care ahead to be robust

New report sets the agenda for monitoring safety

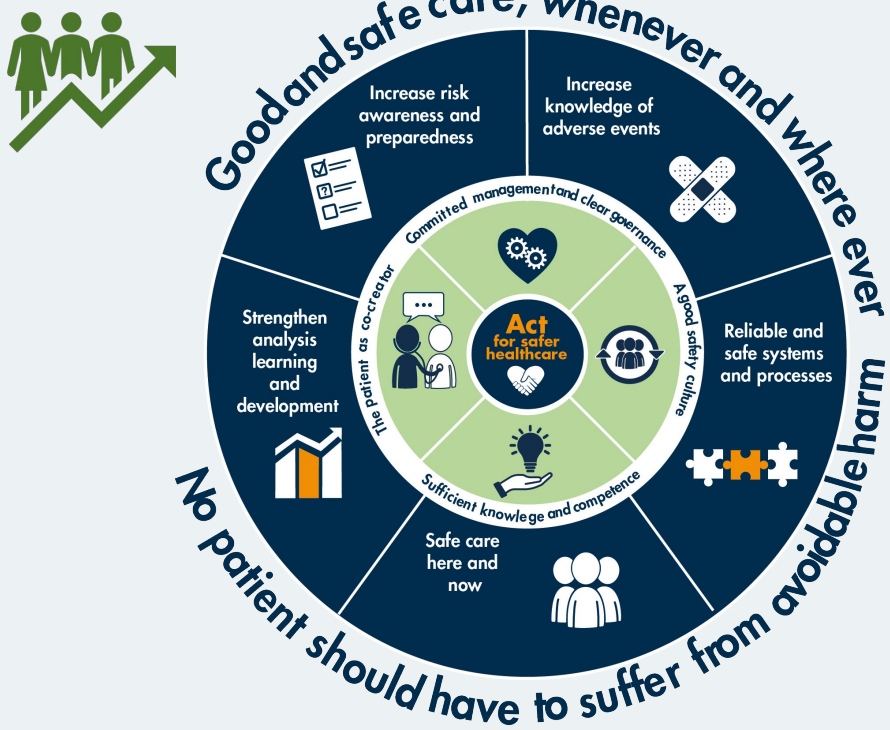
- A first step according to the national action plan
- Already defined indicators reviewed and selected according to the new framework
- The need of additional development for new areas and indicators

How safe is Swedish healthcare?

- Has healthcare been safe?
  Improvements for 9 of 16 indicators
- Is healthcare safe here and now?

  Improvement for 13 of 16 indicators
- Is there risk awareness and preparedness?

  Improvement for 2 of 3 indicators



Thank You All!

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Round-table discussion 2

How do we measure what we need to know?

Thank You All!