Patient safety is not a luxury

The fundamental tenet of medicine, first do no harm, seems obvious for the provision of high quality health care. Yet in the UK alone, on average, one incident of patient harm is reported every 35 seconds. Since the publication of the US Institute of Medicine report *To Err is Human* in 1999, improving reporting of harm and implementing measures to improve patient safety have been prioritised by health-care providers worldwide. However, statistics such as those reported in the UK clearly show that more needs to be done. On March 8–10, 2016, health-care professionals, researchers, and policy makers gathered in London for the Patient Safety Global Action Summit 2016, at which two reports from the National Institute for Health Research Imperial Patient Safety Translational Research Centre were released—*National Reporting and Learning System (NRLS) Research and Development* and *Patient Safety 2030*.

The first step toward reducing patient harm is to understand the magnitude of the issue. This can only be achieved with accurate reporting. In the UK, it is estimated that only 5% of incidents are adequately reported, largely as a result of attempting to avoid blame—that reporting an incident will lead to holding individual health-care workers solely responsible, and putting them at risk of litigation. The *NRLS Research and Development* report outlines a strategy for collating data on patient safety incidents, and effectively balancing anonymised reporting with feedback to drive improvements in patient safety outcomes.

Using antimicrobial resistance as an example, Sally Davies, Chief Medical Officer for England, highlighted the increasing gap between knowledge and implementation of patient safety measures, saying "if only we put into practice what we know, millions of lives could be saved". The *Patient Safety 2030* report, assesses present-day barriers to improving safety (such as the need for increasingly complex care and financial constraints), as well as defining four pillars of a safety strategy: a systems approach to reducing harm, development of a safety culture, involving patients as partners in safety, and a bias toward action based on evidence and reasoned decision making. Gaps in patient safety data are also highlighted. The current evidence base for patient safety has, for the most part, been developed in acute hospital care settings; data across the spectrum of health care, especially in primary care, are urgently needed.

Looking forward, *Patient Safety 2030* provides a toolbox that highlights six areas with high potential to improve patient safety over the next 15 years. Of note, leadership at all levels, including from patients, is needed to strengthen safety in health systems and to foster a culture of safety. Education and training, in particular translating knowledge into practice, is essential for administrators and health-care providers alike. Digital health solutions are approached cautiously in the report, but rigorous evaluation of their effectiveness should be included in the toolbox. The almost ubiquitous use of smartphones and social networking tools has huge potential for measuring safety data, and identifying unexpected sources of increased patient risk. Importantly, changing behaviours is recognised as being fundamental to improving safety.

At the Summit, Donald Berwick, President Emeritus and Senior Fellow at the Institute for Healthcare Improvement, MA, USA, reminded attendees that patient safety must be addressed on a global scale, emphasising that these issues are most crucial in the nations with the fewest resources, whose citizens cannot afford for quality to fail. Although many developing nations have specific health-care challenges, patient safety measures, such as preventing infection and antimicrobial resistance, remain common to all health services. Patient safety is also cost-effective—reducing unnecessary admissions owing to errors in care has the potential to save millions of dollars each year. The recommendations in *Patient Safety 2030* have universal themes that can be adopted by all countries. Specifically, leadership is required to drive changes in safety culture, a consensus of measurement and reporting must be attained, and wireless technologies and social networking tools, which are increasingly accessible in remote areas, have the potential to improve patient safety reporting and reductions in harm.

To err is human. Errors in medicine can and will happen. Structuring health systems and environments to minimise the incidence and impact of human errors is essential and achievable. Improvements in patient safety can only be instituted when the culture of reporting evolves from one of blame to understanding and learning from mistakes. Above all, the patient must be placed at the centre of the conversation. Globally, patient safety needs to be integrated into the foundation of quality care—safety is not a special programme. ■ *The Lancet*

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For the **US Institute of Medicine report *To Err is Human*** see https://iom.nationalacademies.org/Reports/1999/To-Err-is-Human-Building-A-Safer-Health-System.aspx

For ***NRLS Research and Development*** see http://www.imperial.ac.uk/centre-for-health-policy/our-work/patient-safety/patient-safety-conferences-2016/information-and-learning-for-patient-safety/

For ***Patient Safety 2030*** see http://www.imperial.ac.uk/centre-for-health-policy/our-work/patient-safety/patient-safety-conferences-2016/the-patient-safety-global-action-summit-2016--expert-summit/