Supporting Section 5 – guidance on applying Safety-II thinking into current incident management practices

As highlighted in the introduction to the Policy, the NHS Wales Executive are actively seeking the influence of new ways of thinking about safety in relation to incident management to drive improvements to patient safety, outcomes and experience.

A key concept that has become popular in healthcare is that of Safety-II, which is part of the broader concept of resilience in healthcare. Historically, patient safety has typically been assessed by the frequency of adverse events and incidents, resulting in a tendency to measure safety through the absence of events (e.g. are fewer incidents being reported?) (Verhagen, 2022). Central to Safety-II is the concept that safety is a consequence that arises from many elements working dynamically together. In this way, a Safety-II perspective seeks to not only understand *what has gone wrong*, but also *what goes well* and how we can learn from this too.

Importantly, Safety-I and Safety-II are not mutually exclusive; one does not replace the other. The premise of Safety-II is that we can learn from all events, including but not limited to incidents and other adverse events.

There has been a lot of interest in Safety-II thinking in healthcare and while the concepts are being explored at a national level to determine how best we can use these to influence our practices, below are some references and practical suggestions for NHS Wales to consider to start to shift our collective mindset towards these new approaches.

We also welcome suggestions and contributions to this evolving work via PatientSafety.Wales@wales.nhs.uk , including suggestions and references you have found helpful and wish to share.

Practical suggestions

- In individual incident investigations – in addition to considering "what went wrong" in relation to the incident, also consider e.g. what normally happens that means this goes right the majority of the time? How can we incorporate this into our investigation?
- Where an issue has been identified e.g. an audit picks up an issue in a particular ward. In addition to looking at what's happening on that particular ward, are there other similar wards where the issue is not happening where there could be valuable learning about what they are doing that could be exemplary practice?
- Consider picking a topic area of interest unrelated to an incident and examine the systems and processes that enable that work to be carried out safely on a daily basis. There may be learning that comes from the examination that can improve resilience locally but also be shared with other similar areas to help them proactively improve practices.

References & further reading

Hollnagel, E. *et al* (2015) From Safety-I to Safety-II: a white paper. https://www.england.nhs.uk/signuptosafety/wp-content/uploads/sites/16/2015/10/safety-1-safety-2-whte-papr.pdf

Verhagen, M. *et al* (2022) The problem with making Safety-II work in healthcare. BMJ Quality & Safety https://qualitysafety.bmj.com/content/31/5/402

Woodward, S. (2019) Moving towards a Safety-II approach. Journal of Patient Safety & Risk Management https://journals.sagepub.com/doi/full/10.1177/2516043519855264