Safe leadership
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Introduction
The expectations and need to deliver high quality safer care in hospitals and especially in Emergency Departments (EDs) has never been greater. Leadership qualities are required at every stage by every worker in an ED or affiliated to the ED in order for the culture of safety to be embedded into the very fabric of an organisation.

Purposes
This section provides a broad framework that will support all practitioners in developing an understanding of the leadership skills necessary when pursuing excellence in system design and improvement, human factors application and constant vigilance to minimise the risk of significant harm in an ED. It must be accepted that error is always liable to occur but showing leadership in order to minimise the likelihood of significant harm is vital.

Objective 1	*Action*	*Evidence and Resources*
To understand what constitutes a safety leader in the ED.	It is necessary to understand the leadership qualities and skills required of an individual in order to highlight problems with safety, encourage the development of an appropriate culture for safe practice and implement a successful change programme.	**Crossing the quality chasm – a new health system for the 21st century,** Institute of Medicine, 2001 http://www.iom.edu/Reports/2001/Crossing-the-Quality-Chasm-A-New-Health-System-for-the-21st-Century.aspx **Institute for Healthcare Improvement. Framework for Resident Education in Safety and Quality** http://www.ihi.org/offerings/ihiopenschool/resources/Pages/UniversityOfWashingtonResidentEducation.aspx **Transforming healthcare: A safety imperative.** Leape et al Qual Saf Health Care 2009;18:424–428. doi:10.1136/qshc.2009.036954 http://www.npsf.org/wp-content/uploads/2011/10/tranforming-healthcare.pdf **What is patient safety culture – a review of the literature.** Sammer et al Journal of Nursing Scholarship Volume 42, Issue 2, pages 156–165 http://onlinelibrary.wiley.com/doi/10.1111/j.1547-5069.2009.01330.x/abstract *This is a well recognised concept of looking at the 'task-individual-group.'* **Manage Train Learn, Adair's Three Circles**' http://www.managetrainlearn.com/page/adairs-three-circles *This programme breaks leadership up into 5 practices and 10 behaviours.* **Kouzes & Posner – The leadership challenge** http://www.leadershipchallenge.com/home.aspx

Objective 1	*Action*	*Evidence and Resources*
continued		**Scouller J.The three levels of leadership – how to develop your leadership presence, knowhow and skills.** http://www.three-levels-of-leadership.com/blog/tag/james-scouller/
Objective 2	***Action***	***Evidence and Resources***
To understand why systems need good leaders.	Systems need to have leaders at every level who are able to take responsibility for their role in the design and delivery of safer health care. In addition it is important to understand that some of the problems in healthcare, especially in Emergency Medicine, require different modelling and thinking in order to design safer solutions.	**Berwick review into patient safety** https://www.gov.uk/government/publications/berwick-review-into-patient-safety *Step 2 is 'lead and support your staff.'* **Seven steps to patient safety: full reference guide,** The National Patient Safety Agency (NPSA) http://www.nrls.npsa.nhs.uk/resources/?entryid45=59787&p=15 **Re-examining the components of transformational and transactional leadership using the Multifactor Leadership,** Avolio, Bass et al, JOOP 2010 http://onlinelibrary.wiley.com/doi/10.1348/096317999166789/full *This article provides a different way at looking at leadership situations and how to manage them. It includes 'The Cynefin framework' of how leaders can adopt a different framework to manage the complexity of the situation they face.* **A Leader's Framework for Decision Making,** Snowden & Boone Harvard Business Review: 2007 http://www.mpiweb.org/CMS/uploadedFiles/Article%20for%20Marketing%20-%20Mary%20Boone.pdf **Followership in the NHS,** Keith Grint & Clare Holt Kings Fund: 2011 http://www.kingsfund.org.uk/sites/files/kf/followership-in-nhs-commississon-on-leadership-Management-keith-grint-claire-holt-kings-fund-may-2011.pdf
Objective 3	***Action***	***Evidence and Resources***
To become a good safety leader.	To provide a set of resources that can support an Emergency Medicine trainee or Consultant to develop and enhance their skills in system design and human performance leadership resulting in safer care and constant quality improvement. It is important to appreciate that developing leadership	*The NHS leadership academy provides a number of resources to help doctors self-assess their own leadership skills and provides a framework for developing such skills.* **NHS Leadership Academy, *The leadership framework for doctors*** http://www.leadershipacademy.nhs.uk/support/the-leadership-framework-for-doctors/ *This acts as an example of team checklists* **WHO, *Surgical Safety Checklist*** http://www.who.int/patientsafety/safesurgery/tools_resources/SSSL_Checklist_finalJun08.pdf

Objective 3	*Action*	*Evidence and Resources*
continued	skillset in general and especially in the field of safety is a life journey. Building a broad knowledge base and skills are vital and then being able to apply them into safer care in your department may take time. Having a wider perspective, focusing on the basics and being able to think out of the box occasionally whilst having lots of patience is vital.	**The 'How to Guide' for Leadership for Safety,** Patient Safety First, 2008 http://www.patientsafetyfirst.nhs.uk/ashx/Asset.ashx?path=/How-to-guides-2008-09-19/Leadership%201.1_17Sept08.pdf **NHS Patient Safety Resources, *The Manchester Patient Safety Framework*** www.npsa.nhs.uk/patientsafety/improvingpatientsafety/humanfactors/mapsaf/ *The Safer Sign-Out system from the Emergency Medicine Patient Safety Foundation incorporates a checklist system for safer care that includes a team briefing as one of its steps.* **Safer Sign Out** http://safersignout.com **Stephen Covey – The 7 habits of highly effective people.** https://www.stephencovey.com/7habits/7habits.php
Objective 4	***Action***	***Evidence and Resources***
To understand what tools are available when things are not working.	Change is not always easy. Knowing what resources and tools can be used to help quantify where you or your organisation are in your journey to deliver safer care and how to maintain momentum is essential. The road to success is always littered with potholes. Whether you are trying to get staff to attend the Clinical Governance meetings or have been involved in a number of serious incidents that have led to harm, – be patient and persist in your efforts to do the right thing!	*The National Patient Safety Authority is a division of the NHS. It provides a wealth of materials based upon reports of patient safety incidents from healthcare staff across England and Wales. Clinicians and safety experts analyse these reports to identify common risks to patients and opportunities to improve patient safety.* **NHS Patient Safety** http://www.nrls.npsa.nhs.uk/ **Institute for Healthcare Improvement, *IHI Global Trigger Tool for Measuring Adverse Events*** www.ihi.org/IHI/Results/WhitePapers/IHIGlobalTriggerToolWhitePaper.htm *This article discusses applying the Global Trigger Tool to understand the issues.* **The Health Foundation, *Global Trigger Tools*** http://www.health.org.uk/public/cms/75/76/313/2601/global%20trigger%20tools.pdf?realName=InzqMF.pdf **Seven Leadership Leverage Points for Organisation- level Improvement in Health Care.** *Reinertsen J, Pugh M, Bisognano M*. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2005. http://www.ihi.org/knowledge/Pages/IHIWhitePapers/SevenLeadershipLeveragePointsWhitePaper.aspx

Objective 4	*Action*	*Evidence and Resources*
continued		**Behaviours that undermine a culture of safety.** Joint Commission, 2008 http://www.jointcommission.org/assets/1/18/SEA_40.PDF **Error reduction and performance improvement in the emergency department through formal teamwork training: evaluation results of the MedTeams Project**. Morey J, Simon R, Jay G et al. Health Serv Res 2002; 37(6): 1553-81. http://www.ncbi.nlm.nih.gov/pubmed/12546286 *Business world-speak but very easily extrapolated to healthcare.* **What to do when things go wrong,** Scott Berkun http://scottberkun.com/2012/what-to-do-when-things-go-wrong/ **Team Emotional Intelligence: what it can mean and how it can affect performance,** Hillary Elfenbein http://apps.olin.wustl.edu/faculty/elfenbeinh/TeamEI.pdf
Objective 5	***Action***	***Evidence and Resources***
To understand how to measure progress.	Measurement lies at the heart of good science. It is important to have the right systems and culture in place so that you and your team can measure progress and then be able to celebrate success as well as being able to maintain momentum!	**Celebrating safety success on World Day for Safety and Health at Work** http://www.reachsafety.com/index.php/reach-activity/posts/celebrating-safety-success-on-world-day-for-safety-and-health-at-work/ **Center for Innovation in Quality Patient Care, *Measuring the culture of safety*.** http://www.hopkinsmedicine.org/innovation_quality_patient_care/areas_expertise/improve_patient_safety/culture/measuring.html **The measurement and monitoring of patient safety.** Vincent C et al, The Health Foundation 2013 http://patientsafety.health.org.uk/sites/default/files/resources/the_measurement_and_monitoring_of_safety.pdf