Patient safety in the NHS in England and the development of the Healthcare Safety Investigation Branch (HSIB)

Dr Mike Durkin
NHS National Director of Patient Safety

11 May 2016
The NHS is big!

The world's largest employers

- US Department of Defense: 3.2 million employees
- People's Liberation Army, China: 2.3 million employees
- Walmart: 2.1 million employees
- McDonald's: 1.9 million employees
- UK National Health Service: 1.7 million employees
- China National Petroleum Corporation: 1.6 million employees
- State Grid Corporation of China: 1.5 million employees
- Indian Railways: 1.4 million employees
- Indian Armed Forces: 1.3 million employees
- Hon Hai Precision Industry (Foxconn): 1.2 million employees

Sources: US Department of Defense, International Institute of Strategic Studies, Walmart, McDonald’s, NHS Information Service, Scottish Government, Welsh Assembly, Northern Ireland Assembly, Forbes, Indian Railways, Foxconn
Great potential for error – the NHS in England

53,000,000+ people

140,000+ different ways the human body can go wrong

6,000+ medicines for treating diseases

9,000+ ways of treating diseases

ICD10 codes

BNF

OPCS codes
Patient Safety Vision for 2020

We want to support the NHS to become a system devoted to continuous learning and improvement of patient safety.

Increasing our understanding of what goes wrong in healthcare

Enhancing the capability and capacity of the NHS to improve safety

By tackling the major underlying barriers to widespread safety improvement
The National Reporting and Learning System (NRLS)

**INPUTS**
- Reports
  - From Local Risk Management Systems (LRMS) (~120,000/m)
  - From eForms (~490/m)

**PROCESSING**
- Cleansing and anonymisation
- The National Reporting and Learning System (NRLS)

**OUTPUTS**
- Clinical review
- Patient safety alerts
- Conferences, webinars, “Patient Safety First”
- Detailed data for local use
- Official statistics
- My NHS hospital safety (NHS Choices)
- HSCIC Outcomes Framework Indicators
- CQC – serious incidents including Never Events
- MHRA – medicines and devices
- Data sharing agreements – research, specialities

**Advice and guidance**
- “Patient Safety First”
The National Reporting and Learning System (NRLS)

*Patient abuse (by staff/third party)* is mainly used for disclosure of abuse outside healthcare to healthcare staff.
Reporting has come a long way....

Chart 1: Incidents reported from Oct 2003 - Jun 2015
National Patient Safety Alerting System (NaPSAS)

NaPSAS is a three-stage alerting system based on other high risk industries such as aviation.

- **Stage one**: WARNING
- **Stage two**: RESOURCE
- **Stage three**: DIRECTIVE

NaPSAS allows for the timely dissemination of relevant safety information to providers, as well as acting as an educational and implementation resource. Alerts are issued via the Central Alerting System (CAS), and reported compliance is published monthly.
Our ambition for a new Patient Safety Incident Reporting System

The below represents what can considered to be the “core functional requirements” of the future PSIMS as decided by the non-financial benefits assessment, comprising the common elements of all options selected for shortlisting.

**Data taxonomy**
- Re-engineered data model

**Data capture**
- eForms and web interfaces
- Mobile devices and web apps

**Explore & analyse**
- National feedback and clinical review
- Standardised online analysis tools
- Data sharing agreements

**Investigate & manage**
- Incident workflow and management
- Schedule and coordinate tasks
- Define lessons and action plans
- Manage risk register

**Share learning**
- Summative reports and statistics
- Patient safety alerting system
- Online collaborative sharing platform

**Support Functions**
- Central operations and analysis teams
- User profiles and permissions
- Helpdesk and system support

Key:
- common to all shortlisted options
- minor variation between option 13 and all other options
Patient Safety Collaboratives

- 15 collaboratives led with the innovation and expertise of the AHSNs
- Each covers 2-5m population
- Locally owned and run
- A unique opportunity only the NHS can bring
- Largest collaborative patient safety programme in the world
- Stronger by learning together
• Q is a new community led by the Health Foundation and supported and co-funded by NHS Improvement
• Connecting hundreds (ultimately thousands) of people skilled in improvement across the UK: people at the frontline of care, researchers, managers, policy makers, patient leaders and others
• Making it easier to share ideas, enhance skills and make changes that benefit patients
• Future recruitment will commence from the summer
## My NHS Beta

Data for better services

## Performance of hospitals in England

### Filter your results

**Topics**
- Key facts
- Efficiency
- Safety
- Food
- Friends and family test
- Patient Reported Outcomes Measures (PROMs)
- Reporting culture
- 7-day services

**Location**
- Please enter a location or postcode
- Within **England**
- Organisation name

**Update results**

**Showing 1-10 of 1096 results | Results per page 10 | Update | Show shortlist (0)**

### Table

<table>
<thead>
<tr>
<th>Infection control and cleanliness</th>
<th>Care Quality Commission inspection ratings</th>
<th>Recommended by staff</th>
<th>Safe Staffing</th>
<th>NHS England patient safety notices</th>
<th>Patients assessed for blood clots</th>
<th>Open and honest reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Among the best</td>
<td>Outstanding Visit CQC profile</td>
<td>Among the best</td>
<td>101%</td>
<td>Good - All alerts signed off where deadline has passed</td>
<td>96% of patients assessed</td>
<td>Among the best</td>
</tr>
<tr>
<td></td>
<td></td>
<td>with a value of 85.00%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Among the best</td>
<td>Good Visit CQC profile</td>
<td>Among the worst</td>
<td>129%</td>
<td>Poor - Some alerts not signed off after deadline</td>
<td></td>
<td>as expected</td>
</tr>
<tr>
<td></td>
<td></td>
<td>with a value of 57.77%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>As expected</td>
<td>Good Visit CQC profile</td>
<td>Within expected</td>
<td>97%</td>
<td>Good - All alerts signed off where deadline has passed</td>
<td>96% of patients assessed</td>
<td>As expected</td>
</tr>
<tr>
<td></td>
<td></td>
<td>range with a value of 68.23%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OK</td>
<td>Good Visit CQC profile</td>
<td>OK</td>
<td>108%</td>
<td>Good - All alerts signed off where deadline has passed</td>
<td>96% of patients assessed</td>
<td>As expected</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OK</td>
<td>Requires Improvement Visit CQC profile</td>
<td>OK</td>
<td>102%</td>
<td>Good - All alerts signed off where deadline has passed</td>
<td>96% of patients assessed</td>
<td>As expected</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Transparency**

www.nhs.uk/mynhs
## Hospital quality data on ‘My NHS’ website

### Key facts
- CQC inspection ratings
- A&E performance
- Mortality rate
- Recommended by staff
- Infection control and cleanliness
- Number of patients waiting more than 52 weeks
- Friends and Family Test: inpatient

### Efficiency
- Financial performance
- Length of stay
- Agency staff as a percentage of average expenditure
- Reference cost index
- Procurement
- Day case rate

### Safety
- Infection control and cleanliness
- CQC inspection rating
- Recommended by staff
- Safe staffing
- NHS England patient safety notices
- Patients assessed for blood clots
- Open and honest reporting

### Food
- Quality of food
- Choice of food
- Choice of breakfast
- Fresh fruit available
- Food available between meals
- Menu approved by dieticians
- Cost of food services per patient per day

### Friends and family test
- A&E
- Labour ward
- Postnatal ward
- Staff who would recommend hospital for care
- Staff who would recommend hospital as a place to work

### Patient Reported Outcomes Measures (PROMS)
- Health improvements reported by patients after:
  - Hip replacement
  - Knee replacement
  - Varicose vein surgery
  - Groin hernia surgery
Publishing consultant outcomes

- Successful publication of surgeon level data from national clinical audits
- Across 12 specialties
- Helping the NHS drive up quality of care
Never events data

Published monthly since April 2014 on NHS England website*

Data published by:
- month
- type of never event
- number and type by organisation

*Will be published on NHS Improvement website for 2016/17 onwards

Never events declared on STEIS (numbers per month from dataset for publication) 2013/14 and 2014/15

- 2013-14
- 2014-15
Systems investigation leading to strong systemic solution

Wayne Jowett

Died in 2001 aged 19
One month after an IV drug was injected intrathecally (IT) in error

Environment design
Separate, labelled:
- treatment bays, for each procedure
- Fridges, for storage of each drug

System design
- Procedure-specific training
- Local ‘IT’ induction & registration

Process design
- Drugs given on separate days
- IT drug not dispensed until IV drug administration is evidenced

Device design
Spinal syringe incompatible with an IV needle

Standard (National) Strong Systemic Solution
“...the processes for investigating and learning from incidents are complicated, take far too long and are preoccupied with blame or avoiding financial liability. The quality of most investigations therefore falls far short of what patients, their families and NHS staff are entitled to expect.”
What did the HSIB evidence say?

- Function should be as independent as possible in how it operates, and be able to make judgements without fear or favour.
- Both internal and external scrutiny is required.
- It should focus on learning from safety incidents in the NHS as well as being able to investigate system-wide failures, and develop and recommend solutions.
- Key measure of success should be widespread learning to prevent mistakes happening again.
- Access to learning from investigations should be made much easier.
- Patients and staff want more support during investigations.
HSIB listening event with clinicians

key themes that came out of discussions were:

- Fear and blame
- The role and function of the Healthcare Safety Investigations Branch
- Questions about the Healthcare Safety Investigations Branch
- Current investigation system
- People and skills in the new Branch
- Learning
- Trust and honesty
What will the Healthcare Safety Investigation Branch look like

- An independent unit, with only pay and rations from NHS Improvement, acting without fear or favour
- Recruitment underway for a Chief Investigator who will decide how HSIB is run and what it investigates – aiming to be in place by summer
- To be developed around soon to be published recommendations of the HSIB Expert Advisory Group
- Investigations will establish causality and support learning and improvement - not attribute blame
- Recommendations will be made to anyone the Chief Investigator thinks appropriate
- Recommendations will guide national patient safety improvement work as well as the work of national and local organisations
- Acting as an exemplar to promote good investigation practice
- Small number of investigations – roughly 30 each year
“Systems awareness and systems design are important for health professionals, but they are not enough. They are enabling mechanisms only. It is the ethical dimensions of individuals that are essential to a system’s success. Ultimately, the secret of quality is love.”

Professor Avedis Donabedian
Behaviours: through the eyes of our patients

• We prioritise patients in every decision we take
• We listen and learn
• We are evidence-based
• We are open and transparent
• We are inclusive
• We strive for improvement

THANK YOU
mike.durkin@nhs.net
@Mike_Durks