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

Dr Mike Durkin
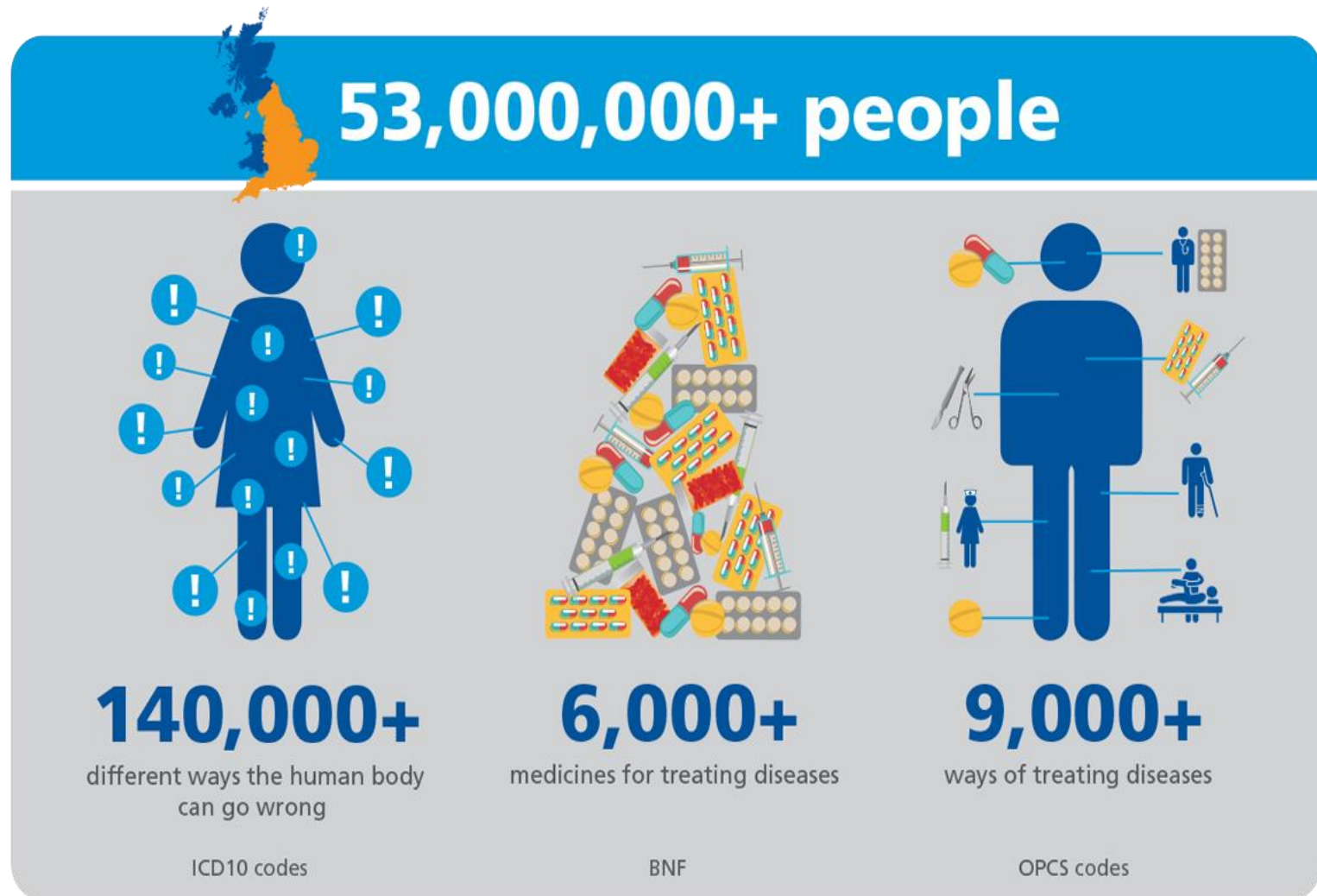**NHS National Director of Patient Safety**

11 May 2016

The NHS is big!

NHS Improvement

The world's largest employers

= 100,000 employees

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

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

NHS *Improvement*

53,000,000+ people

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

ICD10 codes

6,000+
medicines for treating diseases

BNF

9,000+
ways of treating diseases

OPCS codes

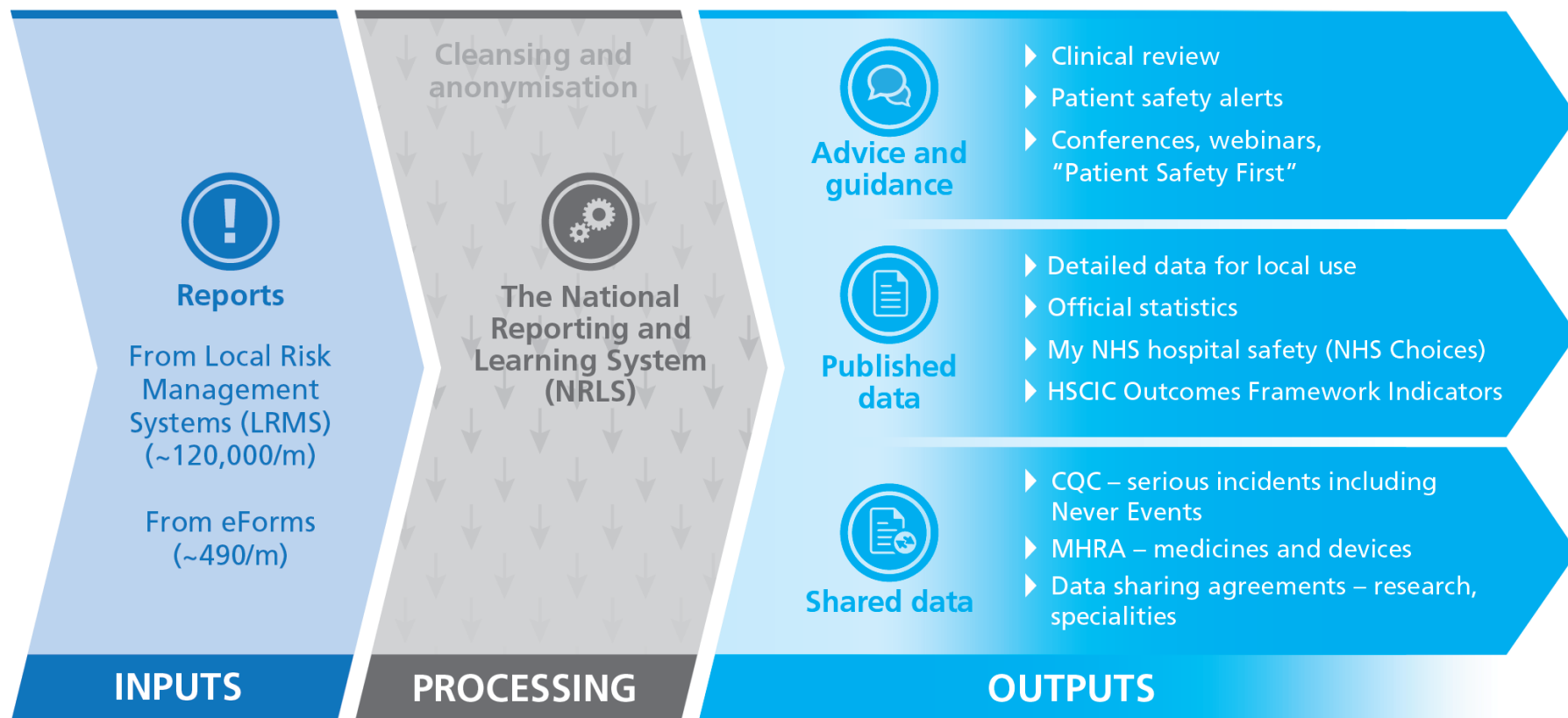# Patient Safety Vision for 2020

NHS
Improvement

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

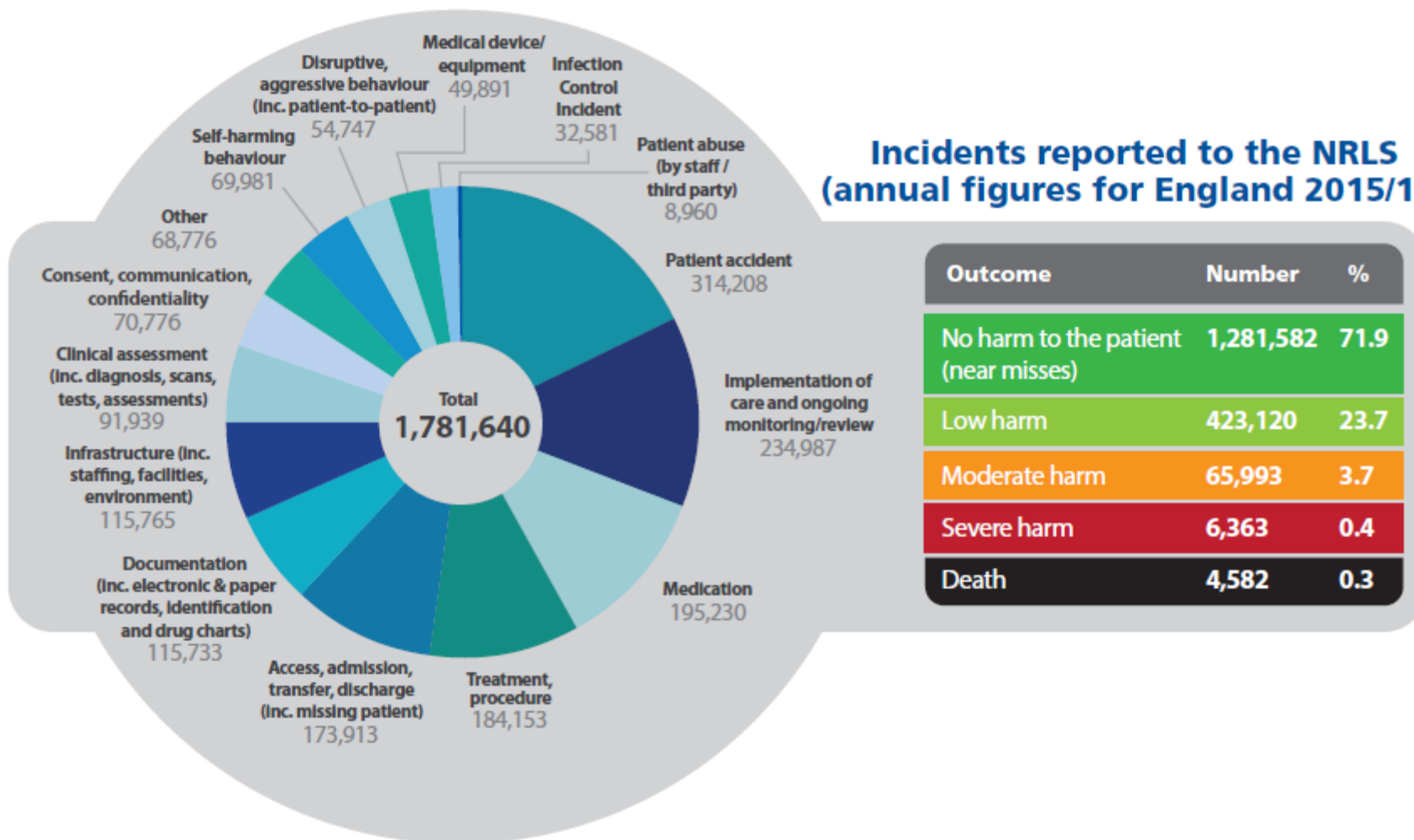**Enhancing the capability and capacity of the NHS to improve safety**

By tackling the major underlying barriers to widespread safety improvement

The National Reporting and Learning System (NRLS)

NHS Improvement

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

Advice and guidance
- Clinical review
- Patient safety alerts
- Conferences, webinars, "Patient Safety First"

Published data
- Detailed data for local use
- Official statistics
- My NHS hospital safety (NHS Choices)
- HSCIC Outcomes Framework Indicators

Shared data
- CQC – serious incidents including Never Events
- MHRA – medicines and devices
- Data sharing agreements – research, specialities

The National Reporting and Learning System (NRLS)

Incidents reported to the NRLS (annual figures for England 2015/16)

Outcome	Number	%
No harm to the patient (near misses)	1,281,582	71.9
Low harm	423,120	23.7
Moderate harm	65,993	3.7
Severe harm	6,363	0.4
Death	4,582	0.3

Pie chart categories:
- Medical device/equipment 49,891
- Disruptive, aggressive behaviour (inc. patient-to-patient) 54,747
- Infection Control Incident 32,581
- Self-harming behaviour 69,981
- Patient abuse (by staff / third party) 8,960
- Other 68,776
- Patient accident 314,208
- Consent, communication, confidentiality 70,776
- Clinical assessment (inc. diagnosis, scans, tests, assessments) 91,939
- Implementation of care and ongoing monitoring/review 234,987
- Infrastructure (inc. staffing, facilities, environment) 115,765
- Documentation (inc. electronic & paper records, identification and drug charts) 115,733
- Medication 195,230
- Access, admission, transfer, discharge (inc. missing patient) 173,913
- Treatment, procedure 184,153
- Total 1,781,640

*'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
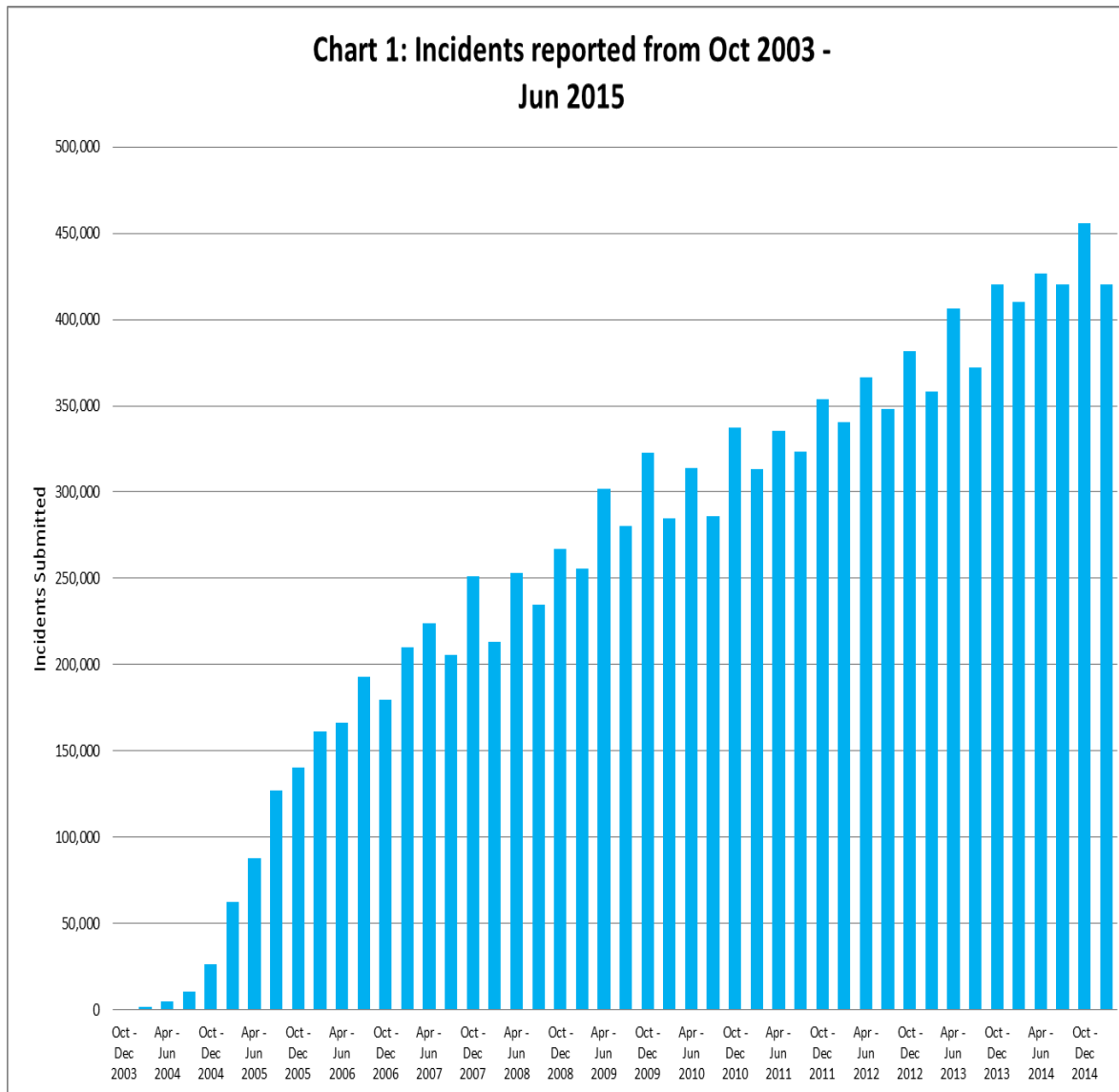
National Patient Safety Alerting System (NaPSAS)

National Patient Safety Alerting System (NaPSAS)

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

WARNING
?
Stage one

RESOURCE
+
Stage two

DIRECTIVE
!
Stage three

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

NHS
Improvement

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

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Patient Safety Collaboratives

NHS *Improvement*

Map legend:
- North East and North Cumbria
- North West Coast
- Greater Manchester
- Yorkshire & Humber
- East Midlands
- West Midlands
- Eastern
- West of England
- Imperial
- UCL Partners
- South London
- Oxford
- Kent, Surrey and Sussex
- Wessex
- South West Peninsula

- 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

Transparency

www.nhs.uk/mynhs

Hospital quality data on 'My NHS' website

NHS Improvement

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

NHS highlights surgeon performance data

Performance data for almost 5,000 surgeons in England has been released by the NHS in a move towards greater transparency.

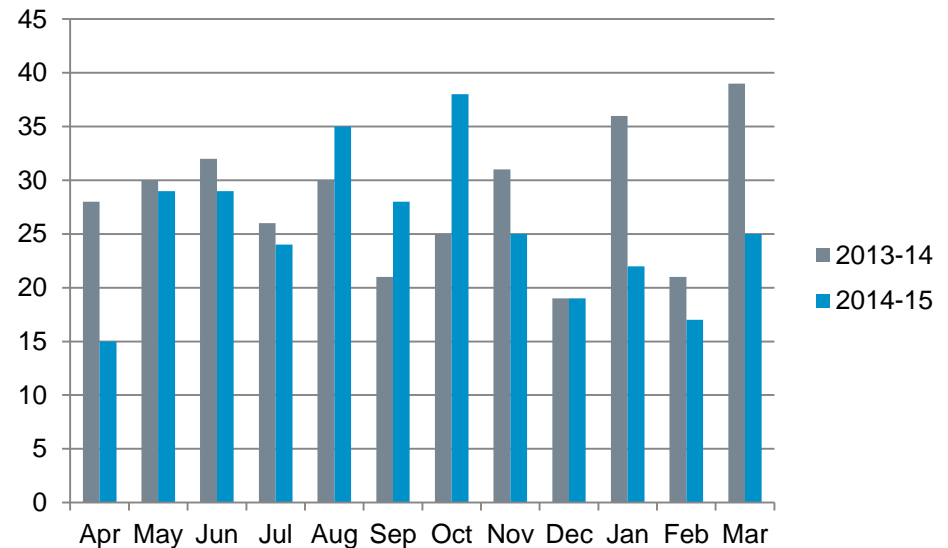# Never events data

NHS Improvement

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

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

Systems based Investigation

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**

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The case for a Healthcare Safety Investigation Branch

NHS
Improvement

"…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."

House of Commons
Public Administration Select Committee

Investigating clinical incidents in the NHS

Sixth Report of Session 2014–15

Report, together with formal minutes relating to the report

Ordered by the House of Commons to be printed 24 March 2015

The HSIB Expert Advisory Group

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 wide spread 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