Patient safety: into the future

Exploring the challenges in patient safety improvement from national, local and personal perspectives

Dr Frances Healey, RGN, RMN, PhD
Head of Patient Safety Insight, NHS England

29 September 2015
Incidents submitted
“…..a system devoted to continual learning and improvement of patient care, top to bottom, and end to end.”

‘A promise to learn – a commitment to act’ August 2013

- Re-launching the patient safety alerts system
- Publishing detailed patient safety data on a dedicated website
- Encouraging the continuation of NHS Safety Thermometer data collection
- Publishing more detailed and regular ‘never events’ data
- Establishing a new Patient Safety Collaborative Programme
- Alignment of patient safety measurement
- Launching Patient Safety Improvement Fellowships and capability building
- Work more effectively with other organisations
“...at the core of [healthcare] are two human beings who have agreed to be in a relationship where one is trying to help relieve the suffering of another, which is love.”

Don Berwick ‘Money-driven medicine’ 2010

“Systems awareness and systems design are important for health professionals, but they are not enough.....ultimately, the secret of quality is love.”

Professor Avedis Donabedian
Patient Safety Collaboratives

A system devoted to continual learning and improvement

Gaining a better understanding of what goes wrong in healthcare

Tackling key patient safety priorities

Vulnerable groups

Vulnerable points of care

Key types of harm

Data

Transparency

NRLS

Retrospective case note review

NaPSAS

SAFE team

NHS England’s Integrated Patient Safety Strategy for the NHS

and reduce harm by 50%

www.england.nhs.uk
National Patient Safety Alerting System (NaPSAS)

- A new system launched in January 2014 for alerting the NHS to emerging patient safety risks
- Builds on the best elements of the former National Patient Safety Agency (NPSA) system
- A three-stage alerting system based on other high risk industries such as aviation
<table>
<thead>
<tr>
<th></th>
<th>H</th>
<th>I</th>
<th>J</th>
<th>K</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>IN05 Incident Category - Lvl1</td>
<td>IN05 Incident Category - Lvl2</td>
<td>IN05 Incident Category Free Text</td>
<td>IN07 Description of what happened</td>
</tr>
<tr>
<td></td>
<td>Clinical assessment (including diagnosis, scans, tests, assessment)</td>
<td>Diagnosis - wrong</td>
<td></td>
<td>58 year old gentleman was brought in with history of out of hospital cardiac arrest at 23:36. Prolonged resuscitation both in and out of hospital. Declared dead at 23:55 by resus team. Subsequently a pulse was felt approximately 20 minutes later. ICU team called back and patient 17 year old boy ( accompanied by this father ), with a past medical history of right testicular orchidectomy for testicular torsion in December</td>
</tr>
<tr>
<td>2</td>
<td>Treatment, Other</td>
<td>Treatment/procedure - Other</td>
<td></td>
<td>Patient attended the Emergency Department after found wandering in shorts &amp; t - shirt only. Brought in by ambulance. Patient found to be cold with blue extremities on arrival. Patient confused and disorientated, seen by ED Doctor deemed medically fit and referred to MHLT. No obvious investigations undertaken by ED to</td>
</tr>
</tbody>
</table>
Potential new risks received from:

- NRLS death & severe
- Coroners
- NHS networks
- Professional bodies
- Other national organisations
- Public/patients
- Clinical audit/mortality

Resolution:

- NO ACTION
  - risk not significant
  - action already underway
  - action not feasible

FOR ACTION BY OTHERS
- Information handed over

NaPSAS ALERT
- 1. Warning
- 2. Resource
- 3. Directive

FOR OTHER ACTION
- e.g. social movements, collaboratives, education, etc.

Triage:

Discussion

NRLS targeted search

Information gathering

Detailed insight from expert groups

Decision
National Patient Safety Alerting System (NaPSAS)

From December 2013 – Sept 2015

27 Alerts issued to date

Stage one: 18
Stage two: 4
Stage three: 5
Widespread challenges never solved by Alerts alone

Rare can be simple

Common is always complex

“Wicked problems”

“Big & hairy problems”
Patient Safety Collaboratives

A system devoted to continual learning and improvement

Vulnerable groups
Vulnerable points of care
Key types of harm

Patient Safety ‘Fellows’

Tackling key patient safety priorities
Gaining a better understanding of what goes wrong in healthcare

SAFE team

NRLS

Retrospective case note review

Data

Transparency

and reduce harm by 50%

NHS England’s Integrated Patient Safety Strategy for the NHS

www.england.nhs.uk
Patient Safety Collaboratives

Our big opportunity

- 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
## PATIENT SAFETY PRIORITY MATRIX

<table>
<thead>
<tr>
<th>TOPIC AREA</th>
<th>PATIENT SAFETY TOPIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>The ‘essentials’</td>
<td>Leadership</td>
</tr>
<tr>
<td><strong>NHS Outcomes Framework Improvement Areas</strong></td>
<td>Falls</td>
</tr>
<tr>
<td>Other major sources of death and severe harm</td>
<td>Nutrition and Hydration</td>
</tr>
<tr>
<td>Vulnerable groups for whom improving safety is a priority</td>
<td>People with Mental Health Needs</td>
</tr>
</tbody>
</table>
Scale of the problem: England
All care settings combined
Over 8,000 reported fatal or severe harm incidents each year

- Suicide/severe self harm: 19%
- Fall (hip #/sub-dural): 17%
- Pressure ulcer grade 4: 14%
- Treatment error or delay: 8%
- Obstetric-specific incident: 6%
- Operation/procedure related: 6%
- Clinical diagnostic error/delay: 6%
- Missed deterioration: 5%
- Medication incident: 6%
- Healthcare associated infection: 6%
- Pulmonary embolus: 5%
- Test results not acted on: 5%
- Transfer or discharge incident: 6%
- Other/unclear: 5%

NRLS post clinical review (after clear reporting errors excluded) April 2013-March 2014 England data: 8,018 incidents
Scale of the problem: Wessex AHSN

• Around 220 people commit suicide each year; around a quarter are known to mental health services; more are known to GPs
• 4,962 VTE cases including 231 deaths related to VTE
• 4,807 patients with grade 2/3/4 pressure ulcers (double to allow for under-reporting in TVS survey)
• 603 cases of C. difficile
• 30 cases of MRSA bacteraemia
• 14,941 NRLS reports of falls in healthcare settings.

Scale of the problem: Oxford AHSN

- Around 195 people commit suicide each year; around a quarter are known to mental health services; more are known to GPs
- 4,370 VTE cases including 204 deaths related to VTE
- 5,259 patients with grade 2/3/4 pressure ulcers (double to allow for under-reporting in TVS survey)
- 481 cases of C. difficile
- 41 cases of MRSA bacteraemia
- 9,225 NRLS reports of falls in healthcare settings.

Patient Safety Collaboratives

A system devoted to continual learning and improvement

- Vulnerable groups
- Vulnerable points of care
- Key types of harm
- Tackling key patient safety priorities
- Improving patient capability and capacity
- Enhancing NHS capability and capacity

- Patient Safety ‘Fellows’
- NaPSAS
- SAFE team

Retrospective case note review

System wide campaign

to save 6000 lives

and reduce harm by 50%

NHS England’s Integrated Patient Safety Strategy for the NHS

www.england.nhs.uk
Preventable deaths due to problems in care in English acute hospitals: a retrospective case record review study

Helen Hogan,^1^ Frances Healey,^2^ Graham Neale,^3^ Richard Thomson,^4^ Charles Vincent,^5^ Nick Black^1^

ABSTRACT

Introduction: Monitoring hospital mortality rates is widely recommended. However, the number of preventable deaths remains uncertain with estimates in 255,000 NHS patients each year suffering serious disability or death as a result of healthcare interventions. This estimate was derived from retrospective case record review.

Main problem types:

- Clinical monitoring (in the broad sense) 31%
- Diagnostic error & delay 30%
- Fluids and medication 21%
- Average 4 problems in healthcare per avoidable death

Learning from preventable deaths: exploring case record reviewers’ narratives using change analysis

Helen Hogan^1^, Frances Healey^2^, Graham Neale^3^, Richard Thomson^4^, Nick Black^1^ and Charles Vincent^5^

Abstract

Objective: To determine if applying change analysis to the narrative reports made by reviewers of hospital deaths increases the utility of this information in the systematic analysis of patient harm.

Design: Qualitative analysis of causes and contributory factors.
Not classic Swiss cheese

“bull’s eye”
Cumulative effect of more minor harms
“death by a thousand cuts”
The most common types of clinically reviewed severe harm and death in ranked order (excluding obstetrics) are:

1. Fall
2. Pressure ulcer grade 4 or above
3. Pulmonary embolus - hospital acquired
4. Treatment error or delay
5. Operation/procedure related incident
6. Clinical diagnostic error, including delay of diagnosis
7. Deterioration not recognised or not acted on
8. Healthcare associated infection
DEATH AND SEVERE HARM REPORTED TO THE NRLS FROM ACUTE HOSPITALS IN:

**Oxford AHSN**

The most common types of clinically reviewed severe harm and death (excluding obstetrics) in ranked order are:

1. Fall
2. Operation/ procedure related incident
3. Pulmonary embolus - hospital acquired
4. Clinical diagnostic error including delay of diagnosis
5. Treatment error or delay
6. Pressure ulcer grade 4 or above
“Patient admitted with confusion following fall and possible long lie. Initial VTE risk assessment correctly identified the patient as having VTE risks & no bleeding risks but patient was not prescribed any chemical prophylaxis as a result of this assessment.

....... Patient was transferred to community hospital after 8 days, a further VTE risk assessment was completed, but again no prophylaxis was prescribed throughout inpatient admission.

[Three weeks later] the patient become unwell with tachycardia and low O2 saturations and was subsequently diagnosed with bilateral Pulmonary Embolism. Due to a failure to provide any thrombo-prophylaxis during the current admission this VTE incident fulfils the criteria for a possibly avoidable hospital acquired thrombosis.”
## PATIENT SAFETY PRIORITY MATRIX

<table>
<thead>
<tr>
<th>TOPIC AREA</th>
<th>PATIENT SAFETY TOPIC</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The ‘essentials’</strong></td>
<td>Leadership</td>
</tr>
<tr>
<td><strong>NHS Outcomes Framework Improvement Areas</strong></td>
<td>Measurement</td>
</tr>
<tr>
<td><strong>Other major sources of death and severe harm</strong></td>
<td>Falls</td>
</tr>
<tr>
<td></td>
<td>Venous Thromboembolism</td>
</tr>
<tr>
<td></td>
<td>Health Associated Infections</td>
</tr>
<tr>
<td></td>
<td>Pressure Ulcers</td>
</tr>
<tr>
<td></td>
<td>Maternity</td>
</tr>
<tr>
<td><strong>Vulnerable groups for whom improving safety is a priority</strong></td>
<td>Avoidable Deterioration of Adults and Children</td>
</tr>
</tbody>
</table>

- Falls
- Venous Thromboembolism
- Health Associated Infections
- Pressure Ulcers
- Maternity
- Nutrition and Hydration
- Handover and Discharge
- Missed & Delayed Diagnosis
- Medical Device Error
- Acute Kidney Injury
- Medication Errors
- Sepsis
- Avoidable Deterioration of Adults and Children

- People with Mental Health Needs
- People with Learning Disabilities
- Children
- Offenders
- Acutely ill Older People
- Transition Between Paediatric and Adult Care
Acute care settings: patient age within death and severe harm incidents

- Over 85 years: 21%
- 76 to 85 years: 9%
- 66 to 75 years: 6%
- 56 to 65 years: 7%
- 46 to 55 years: 17%
- 36 to 45 years: 4%
- 26 to 35 years: 7%
- 18 to 25 years: 6%
- Under 17 years: 3%

NRLS post clinical review (after clear reporting errors excluded) April 2013-March 2014 England data
THE AGE OF PATIENTS AFFECTED BY INCIDENTS REPORTED TO THE NRLS IN:

Wessex AHSN

- Missing age: 19%
- Child (less than 18): 5%
- Adult (18-64): 28%
- Older person (65 or over): 48%

Please note: missing age can be because the data are incomplete, but more often relates to incidents where the harm or potential for harm is not specific to an individual patient (e.g. an equipment failure, staff shortages, etc.).
Please note: missing age can be because the data are incomplete, but more often relates to incidents where the harm or potential for harm is not specific to an individual patient (e.g. an equipment failure, staff shortages, etc.).
Please note: although the majority of the services included in this graph are community/district nursing, therapy services and community hospitals treating patients with physical ill-health, a small proportion of these incidents come from community mental health services/units, and cannot easily be separated out (especially where an organisation provides both types of community services).

*Predominantly used by most trusts to report ‘third party’ abuse i.e. disclosure to healthcare staff of abuse unrelated to healthcare.
MAIN INCIDENT TYPES REPORTED THE NRLS FROM MENTAL HEALTH SERVICES IN:

Oxford AHSN

- Self-harming behaviour: 23%
- Patient accident: 18%
- Disruptive, aggressive behaviour: 18%
- Access, admission, transfer, discharge (including missing patient): 12%
- Medication: 9%
- Infrastructure (including staffing, facilities, environment): 7%
- Treatment, procedure: 4%
- Consent, communication, confidentiality: 2%
- Patient abuse (by staff / third party)*: 2%
- Documentation (including records, identification): 9%
- Others: 12%

Please note: Although the majority of the services included in this graph are community/district nursing, therapy services and community hospitals treating patients with physical ill-health, a small proportion of these incidents come from community mental health services/units, and cannot easily be separated out (especially where an organisation provides both types of community services).

*Predominantly used by most trusts to report ‘third party’ abuse i.e. disclosure to healthcare staff of abuse unrelated to healthcare.
# PATIENT SAFETY PRIORITY MATRIX

<table>
<thead>
<tr>
<th>TOPIC AREA</th>
<th>PATIENT SAFETY TOPIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>The ‘essentials’</td>
<td>Leadership</td>
</tr>
<tr>
<td>The ‘essentials’</td>
<td>Measurement</td>
</tr>
<tr>
<td>NHS Outcomes Framework Improvement Areas</td>
<td>Falls</td>
</tr>
<tr>
<td>NHS Outcomes Framework Improvement Areas</td>
<td>Venous Thromboembolism</td>
</tr>
<tr>
<td>Other major sources of death and severe</td>
<td>Health Associated Infections</td>
</tr>
<tr>
<td>harm</td>
<td>Pressure Ulcers</td>
</tr>
<tr>
<td>Other major sources of death and severe</td>
<td>Maternity</td>
</tr>
<tr>
<td>Other major sources of death and severe</td>
<td>Avoidable Deterioration of Adults and Children</td>
</tr>
<tr>
<td>Other major sources of death and severe</td>
<td>Nutrition and Hydration</td>
</tr>
<tr>
<td>Other major sources of death and severe</td>
<td>Handover and Discharge</td>
</tr>
<tr>
<td>Other major sources of death and severe</td>
<td>Missed &amp; Delayed Diagnosis</td>
</tr>
<tr>
<td>Other major sources of death and severe</td>
<td>Medical Device Error</td>
</tr>
<tr>
<td>Other major sources of death and severe</td>
<td>Acute Kidney Injury</td>
</tr>
<tr>
<td>Other major sources of death and severe</td>
<td>Medication Errors</td>
</tr>
<tr>
<td>Other major sources of death and severe</td>
<td>Sepsis</td>
</tr>
<tr>
<td>Other major sources of death and severe</td>
<td>Avoidable Deterioration of Adults and Children</td>
</tr>
<tr>
<td>Vulnerable groups for whom improving</td>
<td>People with Mental Health Needs</td>
</tr>
<tr>
<td>safety is a priority</td>
<td>People with Learning Disabilities</td>
</tr>
<tr>
<td>Vulnerable groups for whom improving</td>
<td>Children</td>
</tr>
<tr>
<td>safety is a priority</td>
<td>Offenders</td>
</tr>
<tr>
<td>Vulnerable groups for whom improving</td>
<td>Acutely ill Older People</td>
</tr>
<tr>
<td>safety is a priority</td>
<td>Transition Between Paediatric and Adult Care</td>
</tr>
</tbody>
</table>
NHS England’s Integrated Patient Safety Strategy for the NHS

A system devoted to continual learning and improvement

- Enhanced NHS capability and capacity to improve safety
- Tackling key patient safety priorities
- Gaining a better understanding of what goes wrong

Patient Safety Collaboratives

- Vulnerable groups
- Vulnerable points of care
- Key types of harm

NaPSAS

SAFE team

NRLS

Data

and reduce harm by 50%
# PATIENT SAFETY PRIORITY MATRIX

<table>
<thead>
<tr>
<th>TOPIC AREA</th>
<th>PATIENT SAFETY TOPIC</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The ‘essentials’</strong></td>
<td><strong>Leadership</strong></td>
</tr>
<tr>
<td>NHS Outcomes Framework Improvement Areas</td>
<td>Measurement</td>
</tr>
<tr>
<td><strong>Other major sources of death and severe harm</strong></td>
<td>Falls</td>
</tr>
<tr>
<td><strong>Vulnerable groups for whom improving safety is a priority</strong></td>
<td>Nutrition and Hydration</td>
</tr>
<tr>
<td>People with Mental Health Needs</td>
<td>People with Learning Disabilities</td>
</tr>
</tbody>
</table>

Wessex Academic Health Science Network
Perspective

Restoring Trust in VA Health Care

Kenneth W. Kizer, M.D., M.P.H., and Ashish K. Jha, M.D., M.P.H.

Comments open through July 30, 2014

It has been nearly 20 years since the Veterans Health Administration (VHA), the subcabinet agency that oversees the Department of Veterans Affairs (VA) health care system, implemented a series of sweeping reforms that markedly improved quality, boosted access, and increased efficiency.\textsuperscript{1,2} Recent revelations about long wait times for veterans compounded by systematic cover-up by VHA administrators make it clear that reforms are again needed. Apparent manipulation and falsification of wait-time data at more than 40 facilities indicate a serious systemic problem.
The response to NHS Choices publication – simple presentation key?
Are we ready to measure frontline care?

“This [MH unit for older people] has no physio input. Balance and strength assessments never get done”

28% No medical role in fall prevention policy

46% Risk scores incompatible with guidelines

70% No access to new walking aids at weekends

Royal College of Physicians 2012 Report of the 2011 inpatient falls pilot audit
www.rcplondon.ac.uk
NHS England’s Integrated Patient Safety Strategy for the NHS

Patient Safety Collaboratives

- Vulnerable groups
- Vulnerable points of care
- Key types of harm

- NaPSAS
- Data
- Transparency

SAFE team

NRLS

Retrospective case note review

A system devoted to continual learning and improvement

and reduce harm by 50%

www.england.nhs.uk
Monitor/TDA merged body to be called NHS Improvement

16 July, 2015  |  By Ben Clover

The combined provider regulator bringing together Monitor and the NHS Trust Development Authority will be called NHS Improvement, Jeremy Hunt announced this morning.
Patient Safety

Patient Safety Collaboratives

A system devoted to continual learning and improvement

Enhancing NHS capability and capacity to improve safety

Gaining a better understanding of what goes wrong in healthcare

Vulnerable groups

Vulnerable points of care

Key types of harm

Data

Transparency

NaPSAS

SAFE team

NRLS

Retrospective case note review

System wide campaign
to save 6000 lives

and reduce harm by 50%

NHS England’s Integrated Patient Safety Strategy for the NHS

www.england.nhs.uk
## PATIENT SAFETY PRIORITY MATRIX

<table>
<thead>
<tr>
<th>TOPIC AREA</th>
<th>PATIENT SAFETY TOPIC</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The ‘essentials’</strong></td>
<td><strong>Leadership</strong></td>
</tr>
<tr>
<td><strong>NHS Outcomes Framework Improvement Areas</strong></td>
<td>Falls</td>
</tr>
<tr>
<td></td>
<td>Venous Thromboembolism</td>
</tr>
<tr>
<td></td>
<td>Health Associated Infections</td>
</tr>
<tr>
<td></td>
<td>Pressure Ulcers</td>
</tr>
<tr>
<td></td>
<td>Maternity</td>
</tr>
<tr>
<td>Other major sources of death and severe harm</td>
<td>Nutrition and Hydration</td>
</tr>
<tr>
<td></td>
<td>Handover and Discharge</td>
</tr>
<tr>
<td></td>
<td>Missed &amp; Delayed Diagnosis</td>
</tr>
<tr>
<td></td>
<td>Medical Device Error</td>
</tr>
<tr>
<td></td>
<td>Acute Kidney Injury</td>
</tr>
<tr>
<td></td>
<td>Medication Errors</td>
</tr>
<tr>
<td></td>
<td>Sepsis</td>
</tr>
<tr>
<td>Vulnerable groups for whom improving safety</td>
<td>Avoidable Deterioration of Adults and</td>
</tr>
<tr>
<td>is a priority</td>
<td>Children</td>
</tr>
<tr>
<td></td>
<td>Offenders</td>
</tr>
<tr>
<td></td>
<td>Acutely ill Older People</td>
</tr>
<tr>
<td></td>
<td>Transition Between Paediatric and Adult</td>
</tr>
</tbody>
</table>

#safercare
“The consistent delivery of well-executed safe care under typically difficult circumstances tends to go unrecognised" http://m.qualitysafety.bmj.com/content/23/11/880.full

Thank you! @FrancesHealey

frances.healey@nhs.net