Imperial College London

NHS National Institute for Health Research

The Journey to Excellence in Quality and Patient Safety: From measurement to the era of values, ethics and leadership in support of a cultural shift

Mike Durkin,
Centre for Health Policy
Institute of Global Health Innovation, Imperial College London

3rd Patient Safety Ministerial Government Summit,
April 13-14, Tokyo, Japan

The NIHR Imperial PSTRC is a collaboration between Imperial College London and Imperial College Healthcare NHS Trust

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Mail Online

News

Out-of-hours NHS services failed three-year-old boy who died after suffering flu and a chest infection by not sending him to A&E

- Sam Morrish died at Torbay Hospital in South Devon in December 2010
- His parents took him to see health professionals four times in 36 hours
- Devastated family determined to find out why their son was allowed to die
- Scott and Susanna Morrish say they have been let down by the NHS
- Report by Health Service Ombudsman expected to be published this week

By VANESSA ALLEN FOR THE DAILY MAIL

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Our Cultural Shift to Increase the Reporting of Error and Learning to Reducing Harm

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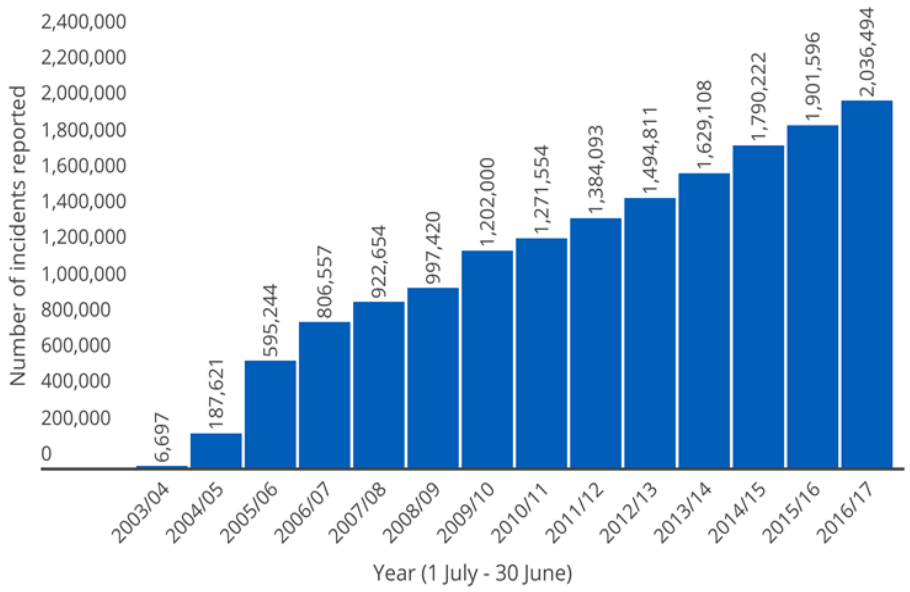
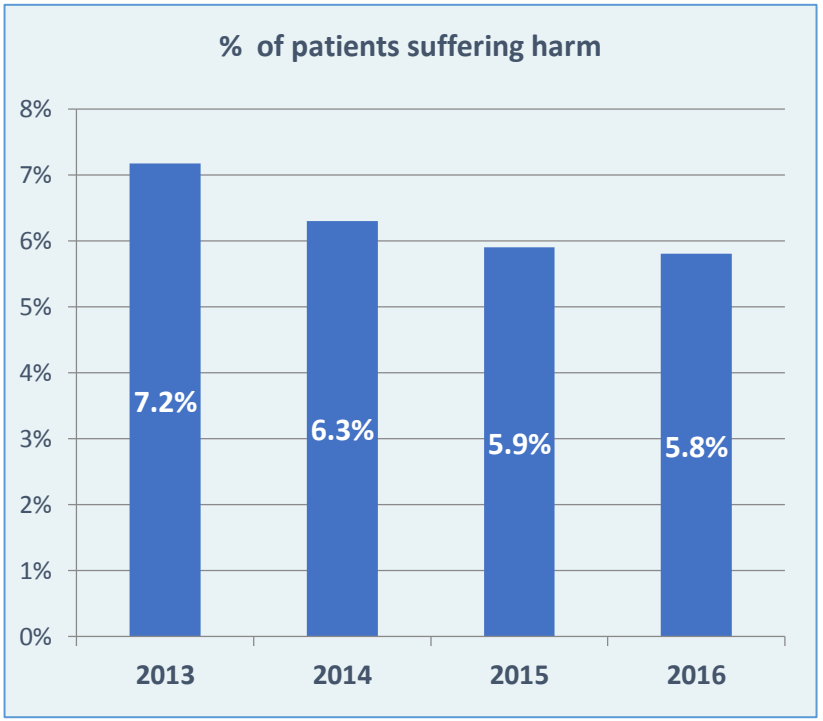
Total patient safety incidents reported to NRLS 1 July to 30 June each year since October 2003 launch (all geographical locations)



An estimated 86,000 fewer patients have suffered harmed due to falling harm rates from 7.2% of patients in 2013 to 5.8% in 2016.



Incidents reported to the NRLS in England 2016/17

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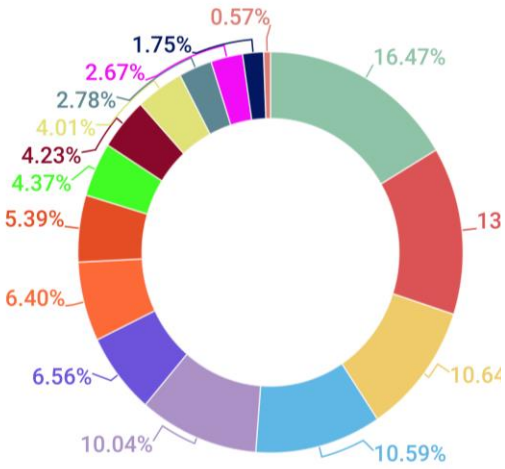

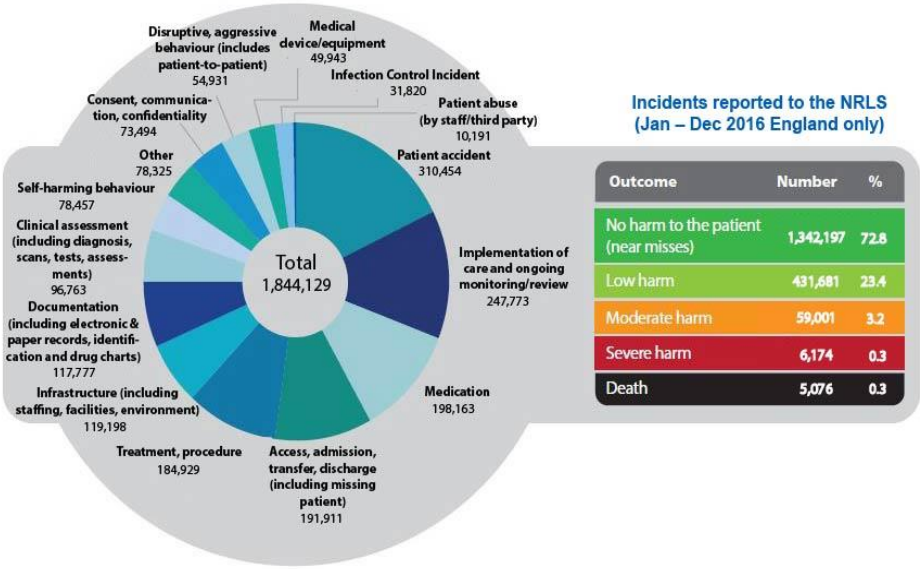

Incidents reported to the NRLS (Jan – Dec 2016 England only)

Outcome	Number	%
No harm to the patient (near misses)	1,342,197	72.8
Low harm	431,681	23.4
Moderate harm	59,001	3.2
Severe harm	6,174	0.3
Death	5,076	0.3

- Patient accident (317,175)
- Implementation of care and ongoing monitoring/review (260,540)
- Medication (204,763)
- Access, admission, transfer, discharge (including missing patient) (203,793)
- Treatment, procedure (193,265)
- Documentation (including electronic & paper records, identification and drug charts) (126,232)
- Infrastructure (including staffing, facilities, environment) (123,218)
- Clinical assessment (including diagnosis, scans, tests, assessments) (103,765)
- Other (84,183)
- Self-harming behaviour (81,442)
- Consent, communication, confidentiality (77,191)
- Disruptive, aggressive behaviour (includes patient-to-patient) (53,589)
- Medical device/equipment (51,433)
- Infection Control Incident (33,719)
- Patient abuse (by staff/third party) (10,973)

1,925,281; total incidents reported 16,288,684

Leadership Ambitions and Actions

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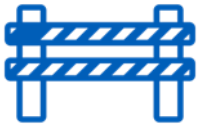
Our ambition is for the NHS in England to become the safest healthcare organisation in the world. In practice this looks like:

- an NHS that **openly and transparently identifies and acts on risks** to patients
- an NHS that **demonstrates a just culture**, where the whole system works to reduce the risk of harm, individuals are **not inappropriately blamed** and there is candour with patients and families when things go wrong

- an NHS where **staff, patients and families are empowered to identify where change is needed** and **are supported to act**, and which also recognises where systemic action is needed.

- We lead a range of initiatives and **operate systems to gain a better understanding of what goes wrong in healthcare**.

- We lead and support programmes to **enhance the capability and capacity of the system to improve safety**.



- We lead and support work with others to **tackle the underlying barriers to safety improvement** in the NHS.

The Report of the Morecambe Bay Investigation

Transforming care:
A national response to Winterbourne View Hospital

Department of Health Review: Final Report

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A PROMISE TO LEARN – A COMMITMENT TO ACT: IMPROVING THE SAFETY OF PATIENTS IN ENGLAND

August 6th, 2013
Don Berwick, MD

BERWICK'S TEN KEY STEPS TO HEAL NHS

- New criminal offences should be created to punish recklessness, wilful neglect or mistreatment by organisations or individuals
- Health bodies that withhold or obstruct relevant information should be subject to criminal sanctions
- A review of 'correct' staffing levels should be held by the National Institute for Health and Care Excellence, but adequate levels determined locally
- Over-complex regulatory system should be simplified, with an independent review of agencies completed by 2017
- Complaints system should be improved, possibly reinstating Community Health Councils
- No duty of candour imposed on individual healthcare workers
- Patient voices must be heeded at all times
- NHS must adopt a culture of learning and improvement by all staff
- Targets must not overtake interests of patients
- All leaders in NHS must put patient safety at top of their priorities

Department of Health

Hard Truths

The Journey to Putting Patients First

The Keogh Mortality Review

Learning not counting

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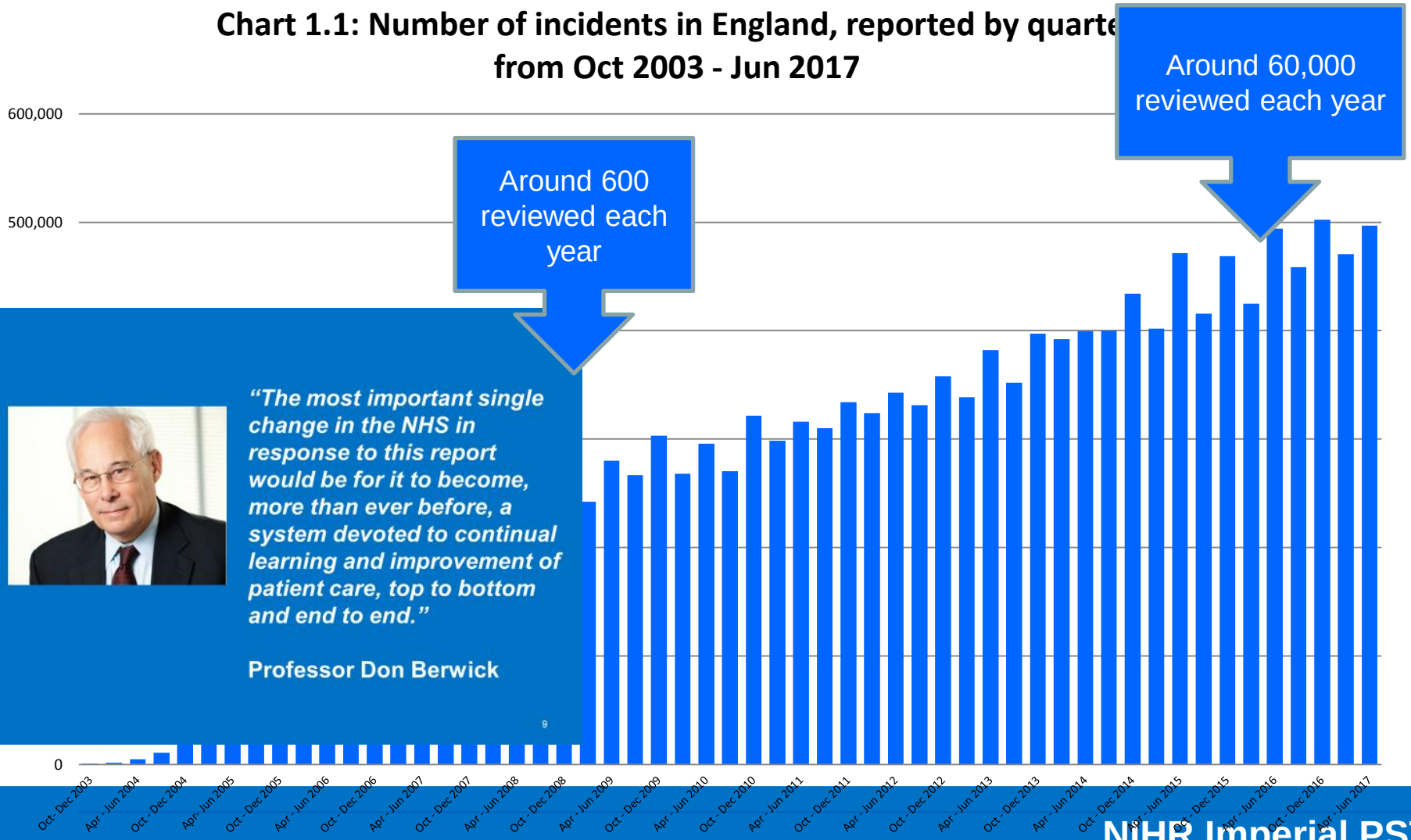
Chart 1.1: Number of incidents in England, reported by quarte
from Oct 2003 - Jun 2017



"The most important single change in the NHS in response to this report would be for it to become, more than ever before, a system devoted to continual learning and improvement of patient care, top to bottom and end to end."

Professor Don Berwick

Fulfilling our statutory duties to collect and review patient safety incidents

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Clinical review: A typical year

c. 19,000 death and severe harm reports subject to clinical review 2014/15 (includes exclusions/duplicates/multiple uploads)

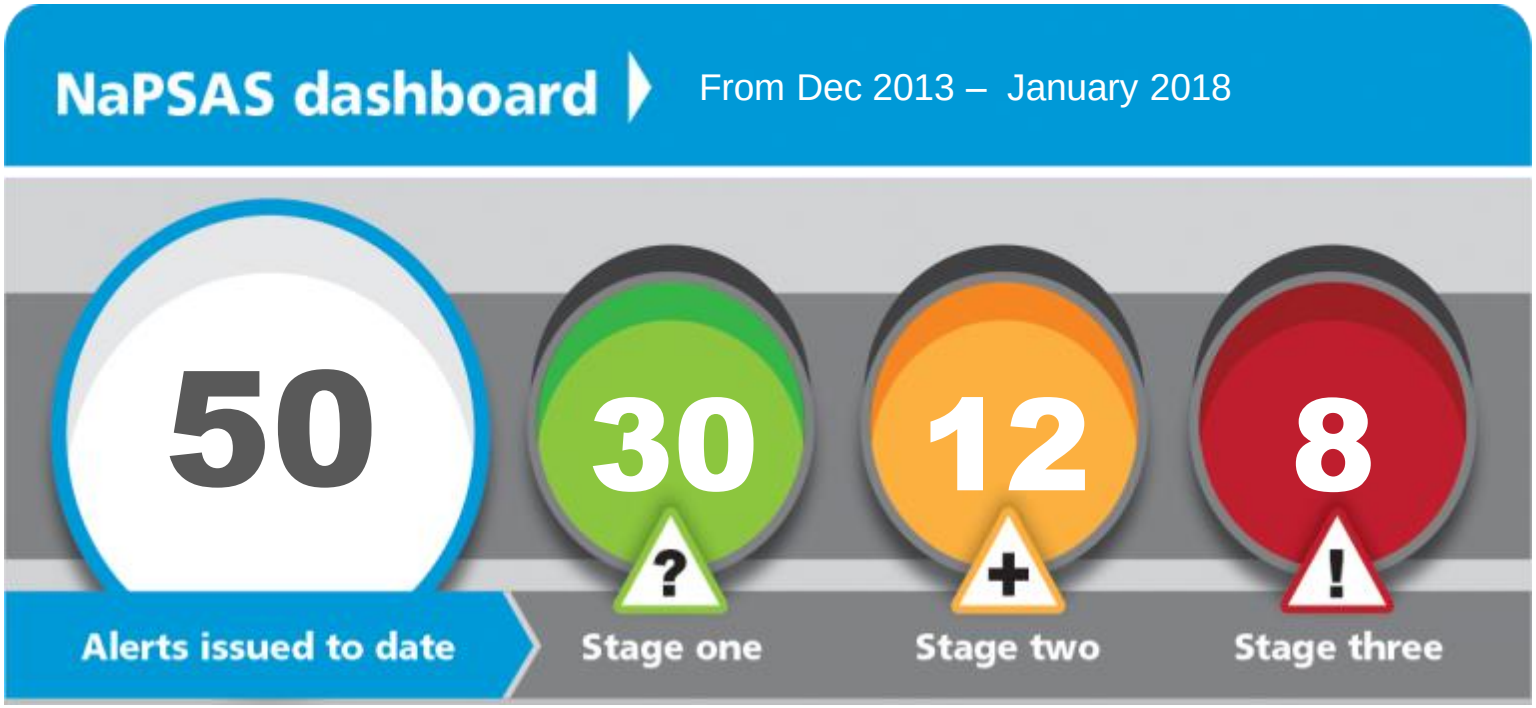
Plus issues from other sources (see next slide)

c. 260 issues taken for multidisciplinary discussion

c. 80 NRLS searches (dives into specific issues)

Providing advice and guidance through Patient Safety Alerts

NHS Improvement



Patient Safety Alert

Nasogastric tube misplacement: continuing risk of death and severe harm

22 July 2016

Patient Safety Alert

Restricted use of open systems for injectable medication

7 September 2016

Patient Safety Alert

Resources to support safer care of the deteriorating patient (adults and children)

12 July 2016

Patient Safety Alert

Stage One: Warning

Risk of death and serious harm from failure to recognise acute coronary syndromes in Kawasaki disease patients

11 May 2016

Widespread challenges never solved by Alerts alone

Rare can be simple

Common is always complex

Collaborative – core clinical priorities

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Topic area	Patient Safety Topic							
The 'essentials'	Leadership				Measurement			
NHS Outcomes Framework improvement areas	Falls	Venus Thromboembolism	Healthcare Associated Infections		Pressure Ulcers		Maternity	
Other major sources of death and severe harm	Nutrition and Hydration	Handover and Discharge	Missed and Delayed Diagnosis	Medical Device Error	Acute Kidney Injury	Medication Errors	Sepsis	Avoidable Deterioration of Adults and Children
Vulnerable groups for whom improving safety is a priority	People with Mental Health needs	People with Learning Disabilities	Children	Offenders	Acutely Ill Older People		Transition between paediatric and adult care	

AMR – a global healthcare threat

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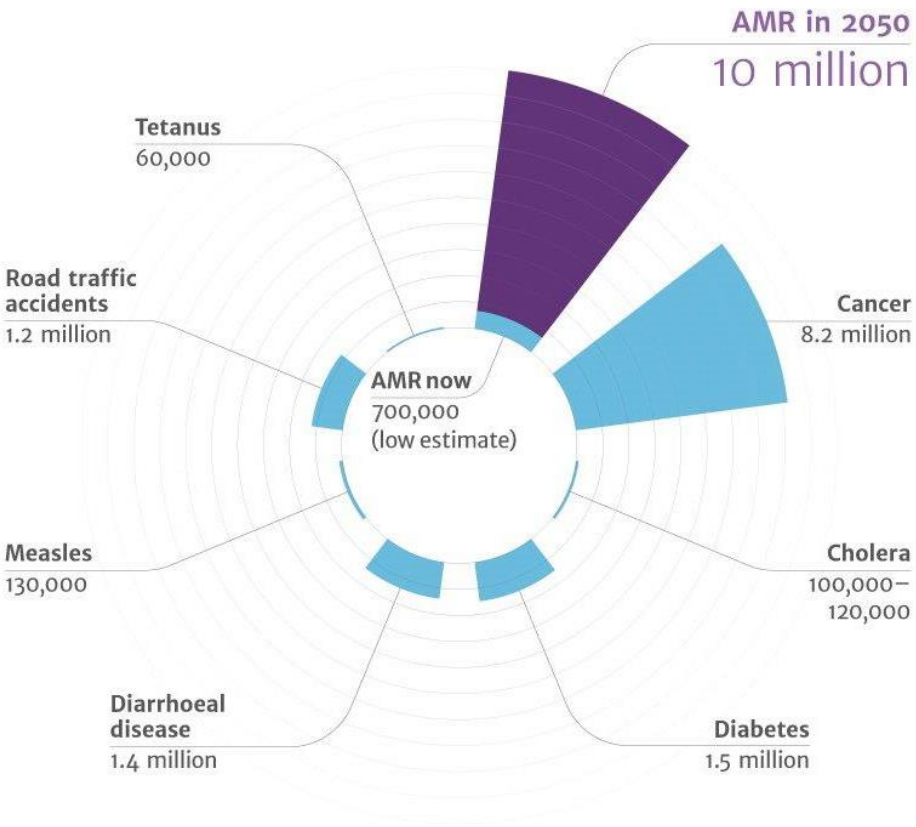
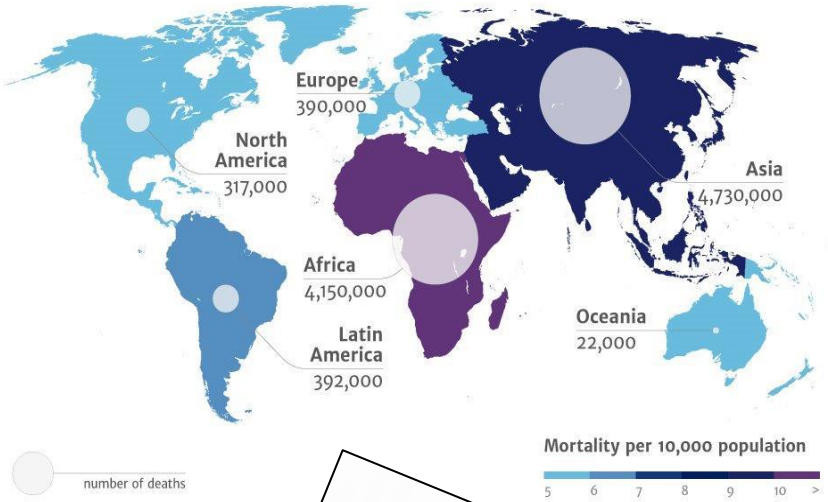
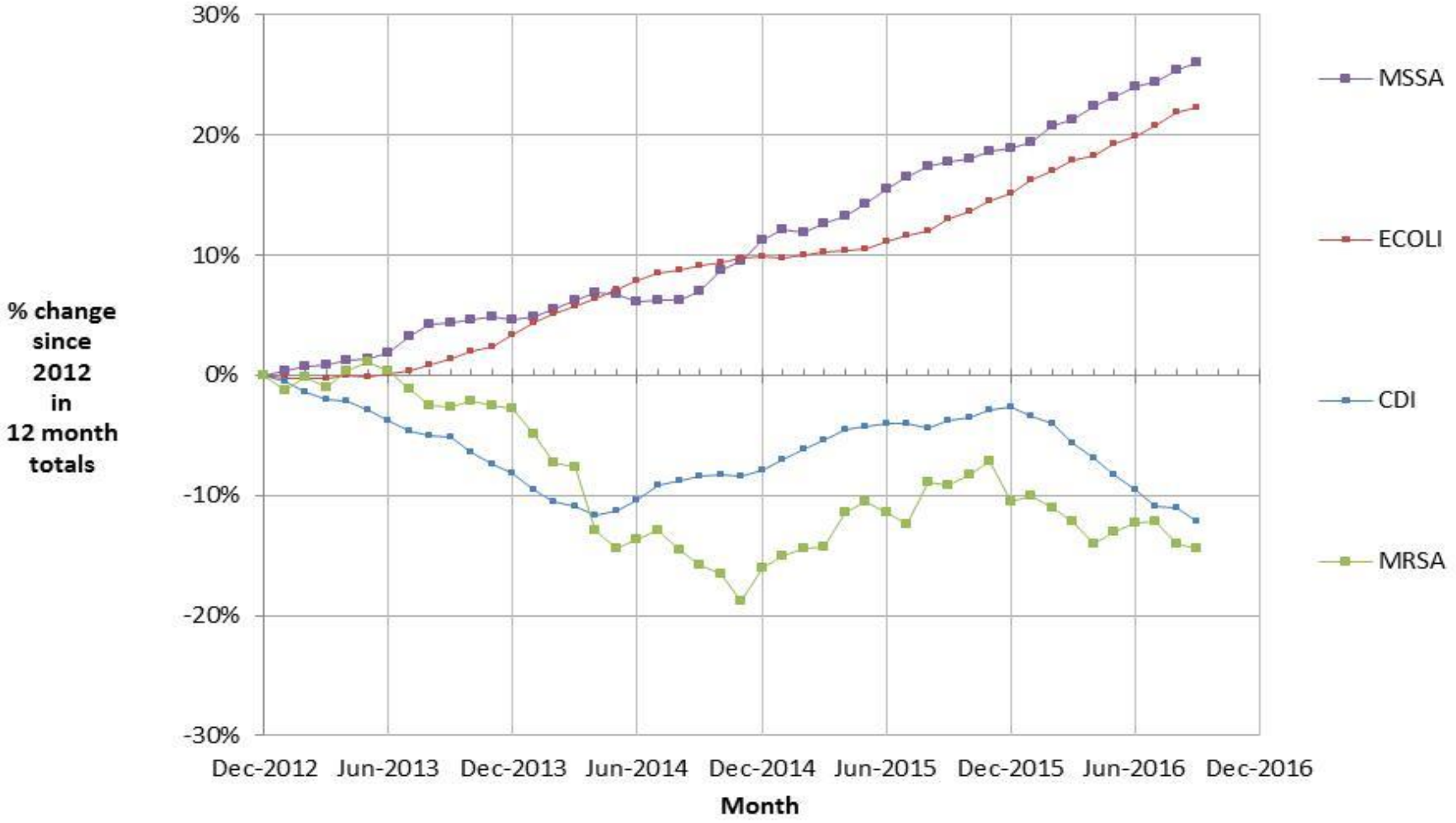




C. difficile infections and MRSA, MSSA and *E.coli* bloodstream infections % change in rolling 12 month totals since the calendar year 2012. December 2012 to September 2016

NHS Improvement



Supporting National Safety Priorities

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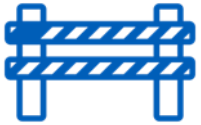
A selection of specific system wide safety priorities:



- Creating the Conditions for a Culture of Safety

- Maternal and Neonatal Safety

- Anti-Microbial Resistance and Infection Prevention and Control

- Improving Recognition and response to Deterioration
- Learning from Deaths and Improving Investigations

- Medication Safety

Transparency means accepting risk to reputations

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Health

A&E in England misses target for whole of winter

By Nick Triggle
Health correspondent

13 March 2015 | Health

The NHS in England has missed its A winter, figures show.

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19 November 2014 Last updated at 09:11

Share

NHS highlights surgeon performance data

Performance data for almost 5,000 surgeons in England has been

theguardian
Winner of the Pulitzer prize

NHS hospital waiting time figures worst in seven years

Almost 40,000 admitted patients not starting consultant-led treatment within 18 weeks of referral

begin treatment reached a record 10 weeks in February. Photograph: Christopher

ortion of NHS hospital patients in England waiting more
n treatment have risen to their highest levels in almost
atistics show.

"…the aim of leadership is not merely to find and record failures of men, but to remove the causes of failure: to help people to do a better job with less effort."

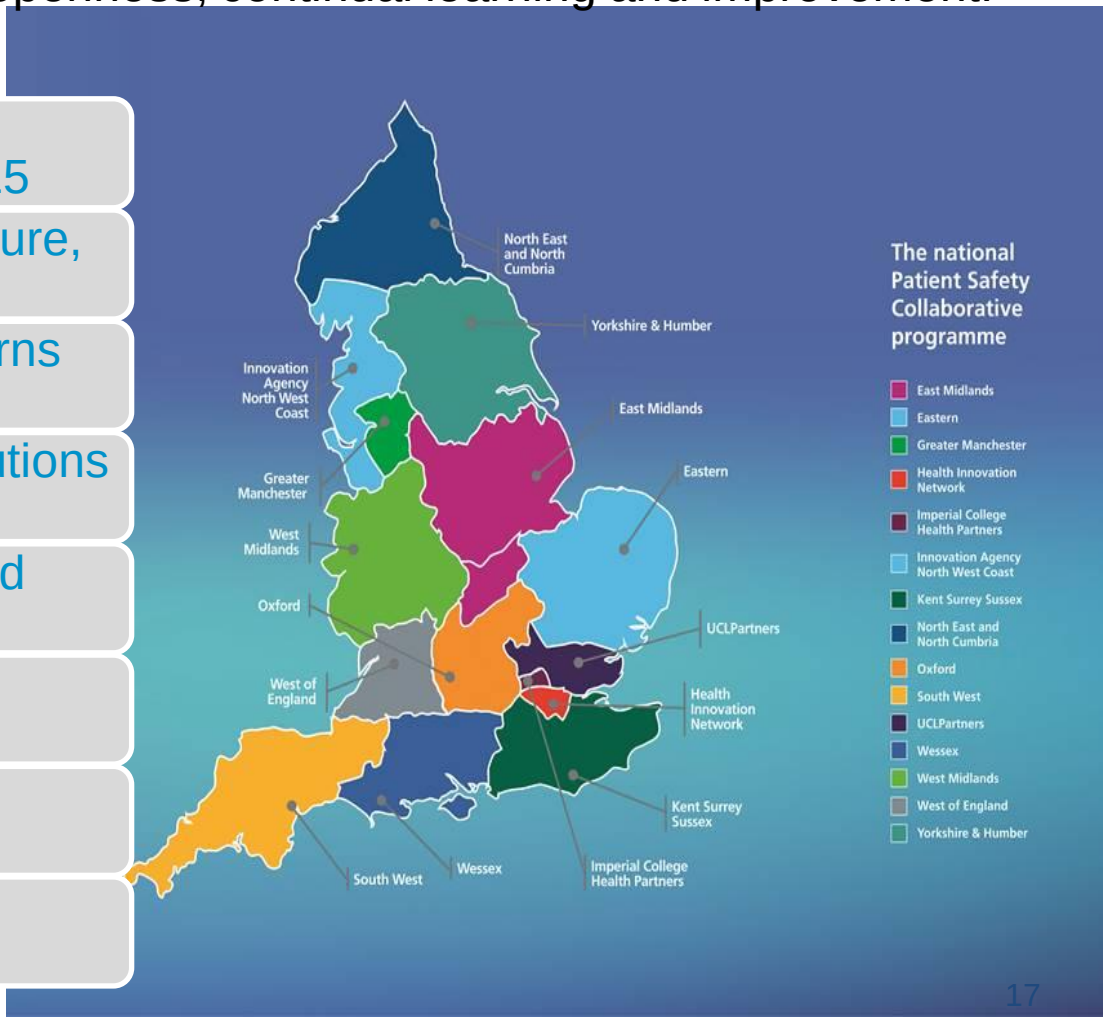
"In God we trust, all others bring data."

Dr W. Edwards Deming

Ongoing oversight of the Patient Safety Collaborative programme in England

Goal: By 2019, everyone (patients and the public) can be confident that care is safer for patients based on a culture of openness, continual learning and improvement.

- Academic Health Science Network funded local delivery mechanism x15
- Primary focus on clinical harm, culture, leadership and measurement
- Local focus on clinical safety concerns across a range of settings
- Test change ideas and develop solutions measure impact
- Improved mechanism for spread and adoption of improvement
- Harness talents - staff, patients, academia and industry
- Build local / regional QI science capability
- Test bed for spread and adoption of innovation and improvement



Learning from Deaths

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"Every hospital should follow every patient it treats long enough to determine whether the treatment has been successful, and then to inquire 'if not, why not' with a view to preventing similar failures in the future." ***Ernest Amory Codman 1914***

- A new consistent NHS-wide case note review methodology has been developed for trusts own use.
- Training in this new methodology has started
- Trust boards will be expected to analyse the results of their own case note reviews to guide improvement
- Also linked to wider system response to CQC review

Original research

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,[3] Nick Black[1]

Learning, candour and accountability

A review of the way NHS trusts review and investigate the deaths of patients in England

Range of related research proposed and in progress via Policy research programme:

- Scale and nature of serious harm in primary care
- Scale and nature of severe harm due to problems in healthcare
- Medical Examiners and identification of preventable deaths due to problems in healthcare

Healthcare Safety Investigation Branch - HSIB EAG Recommendations

INDEPENDENCE, ENGAGEMENT AND LEARNING

1. Must be independent in structure and operation
2. Investigations must be to understand causes of harm, to support improvement, not to apportion blame
3. Patients, families and staff must be active, supported participants

SYSTEM-WIDE INVESTIGATION AND IMPROVEMENT

4. Must be empowered to investigate safety incidents anywhere across the entire healthcare system
5. Investigations must be led by experts in safety investigation and HSIB should provide leadership to the whole system on investigation
6. Investigation reports must explain causes of incidents and make recommendations
7. Reports must be public documents and recipients must publish responses

JUST CULTURE: TRUST, HONESTY AND FAIRNESS

8. Must promote creation of a 'just' safety culture
9. Must provide families and patients with all relevant information from an investigation about their care while protecting all information from use by other bodies or for other purposes
10. Information must be provided to investigators honestly and openly. Where evidence shows wrongdoing, negligence or unlawful activity the relevant body must be informed.

FURTHER ACTIONS REQUIRED ACROSS THE HEALTHCARE SYSTEM

11. Recommend a 'Just Culture' Task Force be established to make further recommendations about moving healthcare to a just culture
12. Recommend a programme of capacity building and improvement of safety investigation
13. Recommend a process to provide truth, justice and reconciliation in relation to unresolved cases

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Independent

Entirely separate from any operational, regulatory, financial, commissioning, improvement or performance management functions and established on a permanent institutional footing

Learning-focused

Acting solely to understand the underlying causes of patient safety issues in order to drive system-wide learning and improvement, without seeking to apportion blame

Expert

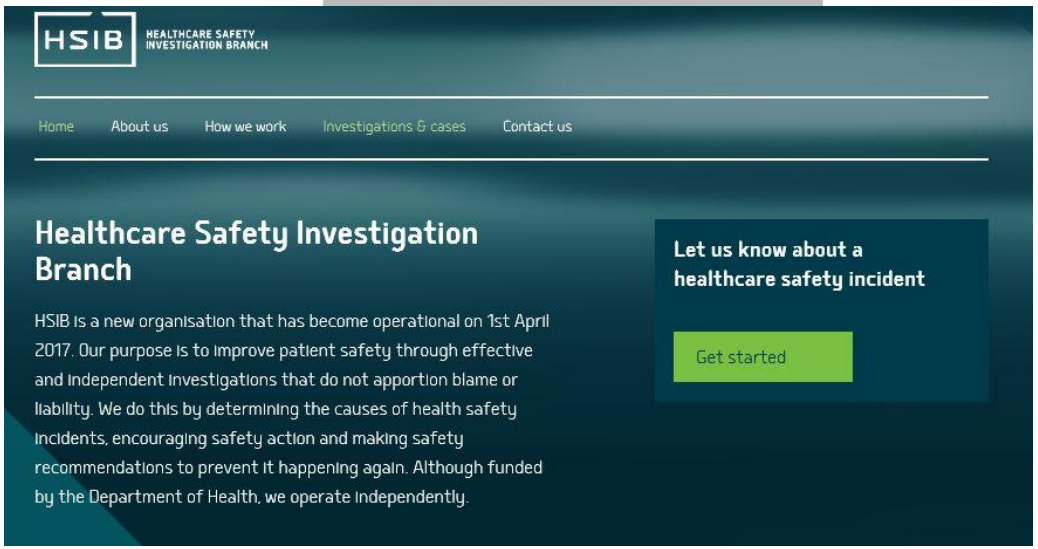
Staffed by experts in safety analysis, improvement science and human factors, with core expertise in the processes and practices of safety investigation

System-wide

Empowered to access, examine, investigate and issue recommendations to all organisations and individuals across the healthcare system, from top to bottom

Trusted

Viewed by patients, professionals and the public as legitimate, impartial and objective in the analysis of risk, the handling of data and the development of safety recommendations



Building an NHS with a culture devoted to trust, honesty, respect and continual learning

Whistleblowing

"When you feel like running away from the patient, run toward the patient."

Paulina Kernberg

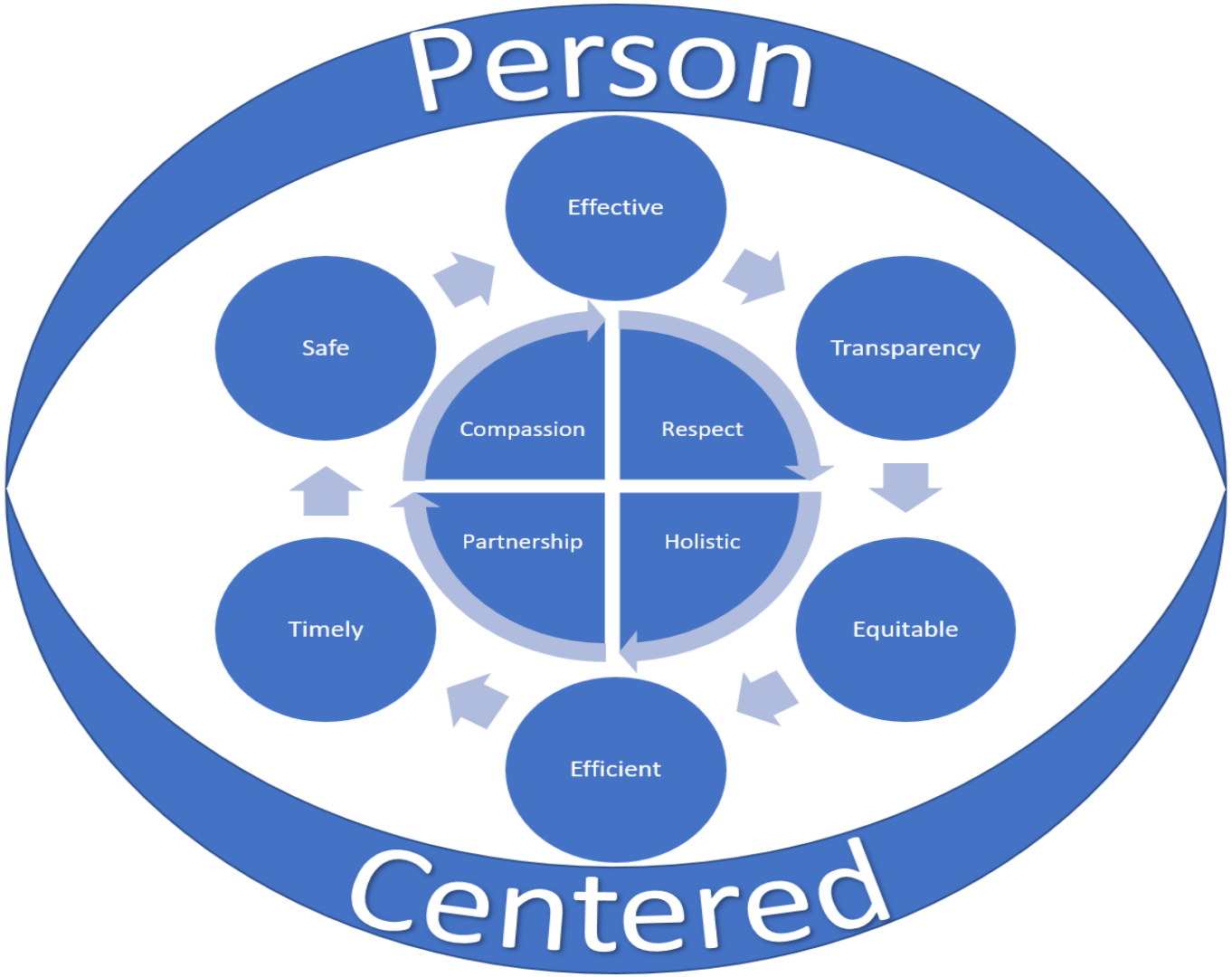
Being Candid

Transparency

Leading with Compassion

Connecting

ISQua's Values and Principles of Person-Centred Care (2015)



Creating Psychological Safety

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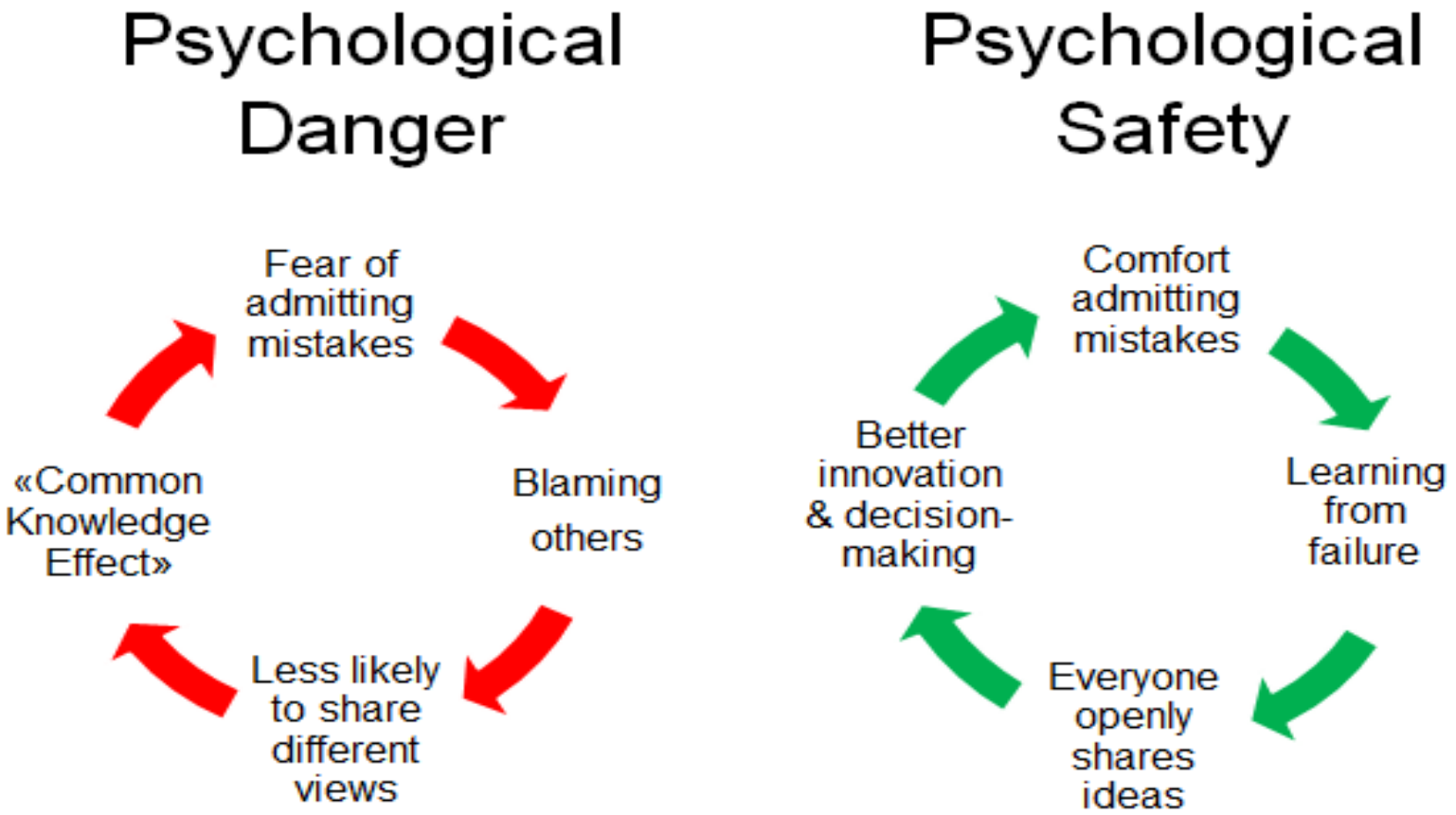
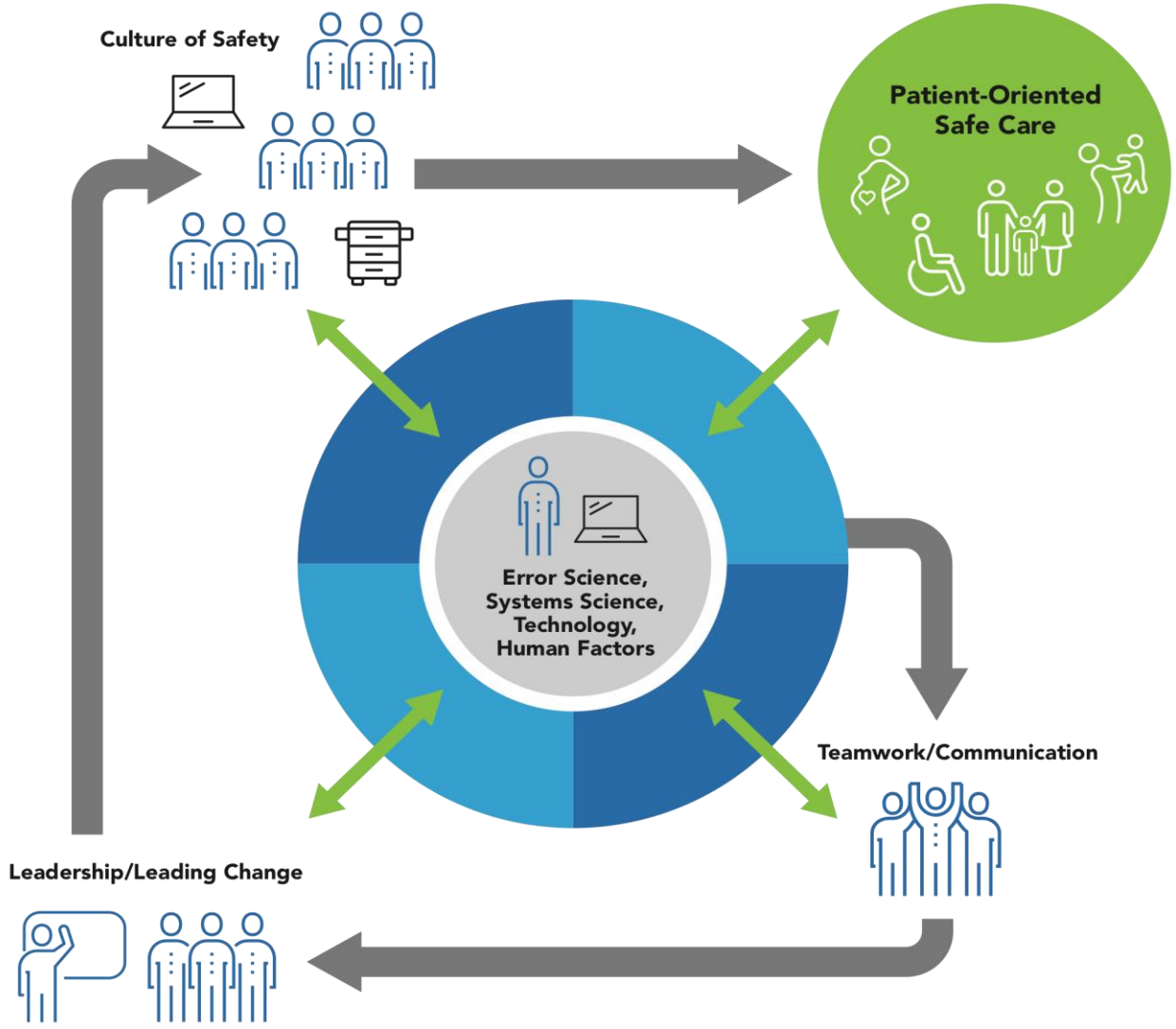


A New (and more relevant?) Curriculum for Interprofessional Education and Training in Patient Safety



Red (high risk: take immediate action)

Many (but not all) children with these features are seriously unwell and need to be assessed straight away in hospital. Dial '999' for an ambulance if necessary.

Skin, lips and tongue

- Very pale or blue skin and sunken eyes
- Rash that does not fade when pressed firmly (use a clear glass)

Activity

- Not responding to carers
- Very difficult to wake up
- Weak, high-pitched or continuous cry in younger children
- Older children are confused or unusually irritable

Breathing

- Finding it much harder to breathe than normal
- Grunting breathing
- Very fast breathing: more than 60 breaths a minute
- Noticeable pauses in breathing

Circulation

- Very cold hands and feet

Temperature and body

- Under 3 months with raised temperature over 38°C
- The soft spot on an infant's head is bulging
- Stiff neck, especially when trying to look up and down
- The child has a seizure

Vomiting, diarrhoea and hydration

- Very thirsty and not able to keep fluids down
- Bloody or black 'coffee ground' vomit
- Not had a wee for 12 hours

Notes

NHS

SAM

Sepsis Assessment & Management

What to look for if your child has a temperature and you are concerned

“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

Imperial College London

NHS National Institute for Health Research

THANK YOU

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The NIHR Imperial PSTRC is a collaboration between Imperial College London and Imperial College Healthcare NHS Trust