Managing patient, staff and public safety in the NHS

Gail Beer, Chair, Healthwatch City of London

18th January 2023

healthwatch City of London

Local and strategic management

- Patient safety systems are a fundamental foundation of the NHS patient safety strategy. Each organisation in the English healthcare system (both NHS and non-NHS) has its own remit and responsibility for improving patient safety.
- Hospitals, general practices and other providers are responsible for the safety of their patients and sharing local information about risks and best practice.
- Patient safety is supported from neighbourhood and place to system, via integrated care systems (ICSs), to ensure the provision of safe care and help to tackle problems that cut across care settings.
- ICS are supported by NHS regional teams and ultimately the NHS England national patient safety team and other national colleagues who co-produce patient safety policy, advice, guidance, strategies and programmes designed to improve safety systems.
- The National Patient Safety committee, established in 2021, brings key national healthcare organisations together to address complex patient safety issues that require cross-organisation effort and input, to make care safer within the

Patient Safety Incident Response Framework (PSIRF) August 2022 (Implementation Autumn 2023)

General Principles

- The PSIRF is a contractual requirement under the NHS Standard Contract therefore mandatory for services provided under that contract, including acute, ambulance, mental health, and community healthcare providers.
- Primary care providers may also wish to adopt PSIRF, but it is not a requirement at this stage.
- Compassionate engagement and involvement of those affected by patient safety incidents
- Application of a range of system-based approached to learning from patient safety incidents
- Considered and proportionate responses to patient safety incidents
- Supportive oversight focused on strengthening response system functioning and improvement

Categorising incidents

Never Events
Serious Incidents
Clinical Incidents
Non –Clinical Incidents

Never events: What are they?

Never events- Serious Incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. May not result in death or serious harm but should not happen.

There is no financial penalty for never events.

Agreeing what is reportable as a never event nationally is agreed between the provider and the commissioner.

Examples:

Wrong site surgery. Wrong implant/prosthesis retained foreign object post procedure.

Administration of medication by the wrong route. Mis-selection of high strength midazolam during conscious sedation.

Failure to install functional collapsible shower or curtain rails. Falls from poorly restricted windows chest or neck entrapment in bed rails, scalding

Transfusion or transplantation of ABO-incompatible blood components or organs . Misplaced naso- or oro-gastric tubes Scalding of patient. Unintentional connection of a patient requiring oxygen to an air flowmeter

All Never events must be reported: National Reporting and Learning System (NRLS)

Serious incidents: A definition

- Serious incidents: adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified.
- Serious incidents include acts or omissions in care that result in; unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm - including those where the injury required treatment to prevent death or serious harm, abuse.

Investigating serious incidents

Discussions with partners (including the police or local authority for example) if other externally led investigations are being carried out. Ensures investigations are managed appropriately, that the scope and purpose is clearly understood (and those affected informed) and that duplication of effort is minimised wherever possible.

Root Cause Analysis (RCA), applied for the investigation of Serious Incidents.

Comprehensive investigations - suited to complex issues which should be managed by a multidisciplinary team involving experts and/or specialist investigators

Independent investigations - for incidents where the integrity of the internal investigation is likely to be challenged or where it will be difficult for an organisation to conduct an objective investigation internally due to the size of organisation, or the capacity/ capability of the available individuals and/or number of organisations involved.

The level of investigation should be proportionate to the individual incident and completed within 60 days and independent investigations within 6 months of being commissioned.

Serious Incidents should be closed by the relevant commissioner when they are satisfied that the investigation report and action plan meets the required standard.

Incidents can be closed before all actions are complete but there must be mechanisms in place for monitoring on-going implementation.

Clinical and non-clinical incidents

An event that causes a loss, injury or a near miss to a patient, staff or others.

Example incidents that should be reported:

Clinical Issues – Medication, poor transfers of care, infection issues, medical device failure, delays in treatment, unexpected outcomes, pressure sores.

Environment Issues – Accidents, violence and aggression, staff ill health directly related to their work.

Professional Issues – Records, breaches of confidentiality, standards, registration. Services – loss of service, loss of data, performance issues, financial loss

All should be reported on Datix

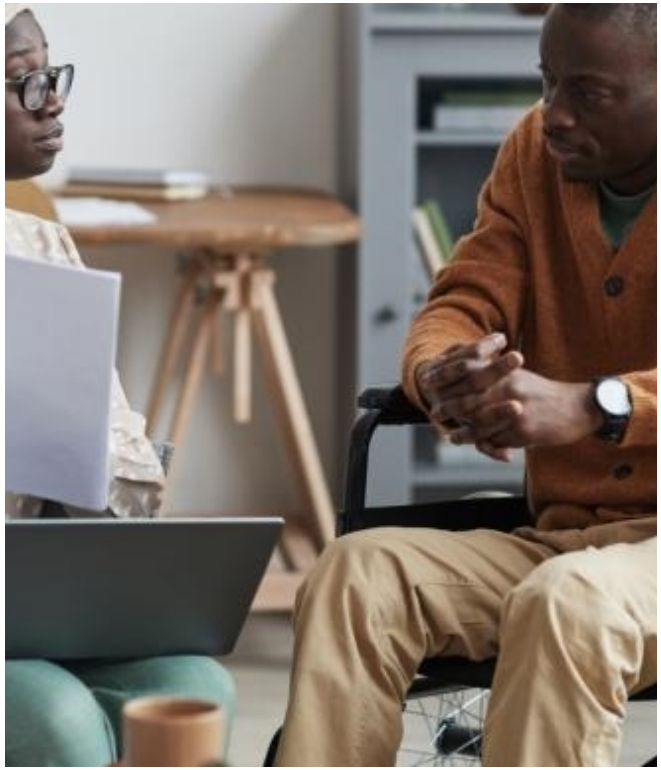
Thematic causes of failure

- Poor leadership
- Lack of training
- Staffing levels and competence to carry out tasks
- Equipment/estate breaks down/staff not trained
- Poor environment
- Culture of an organisation

What should we be encouraging?

- Culture of reporting incidents as need to understand what's happening and identify risks that can be prevented
- Transparency with those affected
- Supportive environment to do RCA and investigations
- Action to change
- Organisational and team learning
- Being open to take external scrutiny and action if required

What should we be looking for?



- Systemic failures
- Repetitive failures
- Failures with common themes
- Preventable failures
- Failure to learn the lessons and implement change
- Not reporting

Any questions?

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