D2: Improving services following adverse events





Adapting to a changing world: equity, sustainability and wellbeing for all











Health Education North East



The Newcastle upon Tyne Hospitals



Complaints – how do they relate to the performance of healthcare organisations? A quantitative analysis of patient complaints and CQC ratings for all NHS hospitals in England

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International Forum on Quality and Safety in Healthcare

Copenhagen

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CQC ratings - Overall



Inadequate

Outstanding

Requires improvement

Good

Provider Name	Overall	Safe	Effective	Caring	Responsive	Well-led
Royal Papworth Hospital NHS Foundation Trust	Outstanding	Outstanding	Outstanding	Outstanding	Outstanding	Outstanding
University Hospitals Sussex NHS Foundation Trust	Outstanding	Outstanding	Outstanding	Outstanding	Outstanding	Outstanding
Christie NHS Foundation Trust	Outstanding	Good	Outstanding	Outstanding	Outstanding	Outstanding
Newcastle upon Tyne Hospitals NHS Foundation Trust	Outstanding	Good	Outstanding	Outstanding	Outstanding	Outstanding
Royal Marsden NHS Foundation Trust	Outstanding	Good	Outstanding	Outstanding	Outstanding	Outstanding
Northumbria Healthcare NHS Foundation Trust	Outstanding	Good	Outstanding	Outstanding	Outstanding	Good
Liverpool Heart and Chest Hospital NHS Foundation Trust	Outstanding	Good	Good	Outstanding	Outstanding	Outstanding
Northern Care Alliance NHS Foundation Trust	Outstanding	Good	Good	Outstanding	Outstanding	Outstanding
Surrey and Sussex Healthcare NHS Trust	Outstanding	Good	Good	Outstanding	Outstanding	Outstanding
Kingston Hospital NHS Foundation Trust	Outstanding	Good	Good	Outstanding	Good	Outstanding
St Helens and Knowsley Teaching Hospitals NHS Trust	Outstanding	Good	Good	Outstanding	Good	Outstanding
Walton Centre NHS Foundation Trust	Outstanding	Good	Outstanding	Outstanding	Good	Good
South Warwickshire NHS Foundation Trust	Outstanding	Good	Good	Good	Outstanding	Outstanding

Complaints (2021-2022) = 105,506Complaints in NHS hospitals = 70,083

MOST COMPLAINTS

- 1. University Hospitals of Leicester NHS Trust (n=2,319)
- 2. Barts Health NHS Trust (n=1790)
- 3. University Hospitals Birmingham NHS Foundation Trust (n=1709)
- 4. Manchester University NHS Foundation Trust (n=1,619)
- 5. Mid and South Essex NHS Foundation Trust (n=1,555)

LEAST COMPLAINTS

- 1. Liverpool Heart and Chest Hospital NHS Foundation Trust (n=38)
- 2. Royal Papworth Hospital NHS Foundation Trust (n=39)
- 3. Royal Orthopaedic Hospital NHS Foundation Trust (n=43)







NHS Hospitals	CQC ratings in 2019	CQC ratings in 2022	Change
Birmingham Women's and Children's NHS Foundation Trust	Outstanding	Good	Deteriorated
County Durham and Darlington NHS Foundation Trust	Requires improvement	Good	Improved
East Sussex Healthcare NHS Trust	Requires improvement	Good	Improved
Epsom and St Helier University Hospitals NHS Trust	Requires improvement	Good	Improved
North Bristol NHS Trust	Requires improvement	Good	Improved
Northampton General Hospital NHS Trust	Good	Requires improvement	Deteriorated
Portsmouth Hospitals NHS Trust	Requires improvement	Good	Improved
Royal Papworth Hospital NHS Foundation Trust	Good	Outstanding	Improved
Sheffield Teaching Hospitals NHS Foundation Trust	Good	Requires improvement	Deteriorated
South Tees Hospitals NHS Foundation Trust	Good	Requires improvement	Deteriorated
South Warwickshire NHS Foundation Trust	Good	Outstanding	Improved
The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	Inadequate	Requires improvement	Improved
University Hospitals Birmingham NHS Foundation Trust	Good	Requires improvement	Deteriorated
University Hospitals Bristol NHS Foundation Trust	Outstanding	Good	Deteriorated
University Hospitals Coventry and Warwickshire NHS Trust	Requires improvement	Good	Improved
Warrington and Halton Hospitals NHS Foundation Trust	Requires improvement	Good	Improved
West Suffolk NHS Foundation Trust	Outstanding	Requires improvement	Deteriorated
Worcestershire Acute Hospitals NHS Trust	Inadequate	Requires improvement	Improved







Regular reporting of patient complaints as an early indicator of clinical performance

PRINCIPAL ROLE: Hospital managers





Feedback on performance

- Corrective actions
- Rewards or penalties
- Budgetary controls



Provider Name	Total staff FTE	New complaints per thousand staff	CQC overall ratings
Walton Centre NHS Foundation Trust	1,363	59.42381	Outstanding
Liverpool Heart and Chest Hospital NHS Foundation Trust	1,727	22.00703	Outstanding
Royal Papworth Hospital NHS Foundation Trust	1,852	21.05486	Outstanding
Christie NHS Foundation Trust	3,032	44.53122	Outstanding
Kingston Hospital NHS Foundation Trust	3,263	170.1114	Outstanding
Royal Marsden NHS Foundation Trust	4,016	26.39685	Outstanding
South Warwickshire NHS Foundation Trust	4,225	33.60955	Outstanding
Surrey and Sussex Healthcare NHS Trust	4,341	181.0563	Outstanding
St Helens and Knowsley Teaching Hospitals NHS Trust	6,015	43.88929	Outstanding
Northumbria Healthcare NHS Foundation Trust	7,152	58.44304	Outstanding
University Hospitals Sussex NHS Foundation Trust	14,270	67.76284	Outstanding
Newcastle upon Tyne Hospitals NHS Foundation Trust	14,283	38.85763	Outstanding
Northern Care Alliance NHS Foundation Trust	16,921	41.01428	Outstanding







The Newcastle upon Tyne Hospitals NHS Foundation Trust







Thank you for listening

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REGION



Learning from Patient and Relative Reported Adverse Events

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Patient safety Legislation

- 2003 Denmark became the first country in the world to legislate on patient safety, (Law on Patient Safety in Health Care.)
- A result of the law was that a reporting system was established
- 2004 it became mandatory for healthcare professionals to report unintended event- confidential through the Danish Patient Security Database (DPSD)





Patient safety Legislation

- 2010 the obligation to report was expanded to include the municipal health sector, practice sector, private hospitals, specialist doctors and the pharmacy sector
- 2011 Patients and relatives got the opportunity to report unintended events





Rigshospitalet

Field of application

• The reporting obligation includes:

- Healthcare activities, including pre-hospital activities
- Events that a reporting person observes in connection with the occurrence of events, including events that they themselves are implicated in as incidents they observe with other healthcare professionals, etc. In addition, reporting obligations include events that a reporting person subsequently becomes aware of in connection with their professional activities





Patient safety Legislation

 The reporting person may not be subject to disciplinary investigations and measures by the employer, supervisory responses by the National Board of Health or criminal sanctions of the courts.





Patient safety Legislation

A patient or a relative may report an unintended incident to a region, municipality or private hospital,

There is no time limit for reporting from patients or their relatives.







Aim of the study

• To understand the patients' and relatives' perspective and focus on

- Patient safety in their contact with the hospital service
- The problems with patients and relatives experience in connection with communication with health care personnel
- The response to patients' and relatives' information about the course of the disease and description of symptoms
- The patients understanding of their disease and prognoses





Rapported Adverse events 2017 -2021 Denmark Who reports ?







Figur 11. Antal rapporterede utilsigtede hændelser rapporteret af patienter og pårørende i perioden 2019-2021



Non professionel reports; Rigshospitalet







Numbers of adverse event scoring Rigshospitalet









The Use of Adverse Incients; Rigshospitalet

- All adverse events at the Rigshospitalet are reported to two central Risk Managers who, in connection with this process, mark the report with a topic word taken from a prepared list, and DPSD main group, problem and process are recorded. In addition, data mining is carried out in the incident description
- These information's are extracted from the database into an excel sheet and aggregated from there





REGION



Number of adverse events from patients and relatives, main groups

Concrete issues

Pressure ulcers

- Failure to recognize the risk of pressure ulcers
- Lack of recognition of pressure ulcers

Record keeping

- Failure to record essential information
- Significant telephone information not noted in the record
 - Metabolic disease
 - Pregnancy





Concrete issues

Investigation and monitoring

- Lack of examination for pregnancy preoperatively
- Lack of monitoring of women after childbirth
- Acceptance of x-rays with suboptimal quality and incorrect angles







Sources of learning

- Unintended events
- Compensation cases
- Complaints
- National clinical databases
- Electronic Health Reports (EHR)





Conclusion Communications issues

- a. A common feature is an expression of a lack of communication of information to the patients and information about the patient to relatives including the diagnostic and treatment process
- b. Reports shows relatives' lack of understanding that in several contexts it is the patient who decide the choice and level of treatment And who should be contacted as well as what information must be shared
- c. Health care personals failure to respond to symptoms



23-05-2023 Rigshospitalet

Conclusion

- There is great learning potential reported adverse events
- Combined with reviewing complaints and compensation cases, especially from those rejected, the general conclusions can be drawn:
 - It is very often a matter of unfulfilled expectations
 - Lack of understanding of the body's functions, anatomy, the disease and thus the treatment
 - The patient's lack of insight into the severity of their illness.



Rigshospitalet

• You have reached your destination"





Rigshospitalet







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Improving more by investigating less: rethinking patient safety incident response

International Forum on Quality and Safety in Healthcare, Weds 17 May

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Policy context

NHS England **Serious Incident** Framework Supporting learning to prevent recurrence "The Framework aims to facilitate learning by promoting a fair, open, and just culture that abandons blame as a tool and promotes the belief that

and just culture that abandons blam as a tool and promotes the belief the 'incidents cannot simply be linked to the actions of the individual healthcare staff involved but rather the system in which the individuals were working'"



"Despite pockets of best practice, good intentions and strong leadership, clinical incident investigation and complaints handling fall far short of what

OPEN ACCESS	The problem with analysis	root cause	SMJ Qual 5		The problem with	'5 whys'	U Qual Set
UPEN ACCESS	unurysis		of fest		Alan J Card		fistp
	Mohammad Farhad Peerally, ¹ Susan Mary Dixon-Woods ¹	Carr, ² Justin Waring, ³	published	Correspondence to Dr Alan / Card, Evidence-Rased Health Solutions, LLC, PD Box 82, Noter Dame, 78 48556,		ial topics related to efforts to improve health- but deceptively difficult strategies for improve- ist solution.	bished as
SUPPORT, Department of Health Sciences, University of Lenceday, Lenceday, SK	INTRODUCTION Attempts to learn from high-risk indus- tries such as aviation and nuclear power	Box 1 Lessons not learnt	86 10.11	1554; alar. j. card@pnal.com Accepted 13 August 2016 Published Drine Fait	BACKGROUND	cause, which illustrates the importance of	10.113
Tode Walk Resultant, University Waspitals of Lelonder, Leionster, UK "CHUL, Nottingham University	have been a prominent feature of the patient safety movement since the late	This example provides a summary of a real case that occurred in a hospital and the	36.bmj	2 September 2016	The '5 whys' technique is one of the most widely taught approaches to root- cause analysis (RCA) in healthcare. Its use	digging deeper into a causal pathway. This quick and easy learning experience can be a powerful lesson in systems safety	a triange
Business School, University of Nottingham, Nottingham, UK	1990s. One noteworthy practice adopted from such industries, endorsed by health- care systems worldwide for the investiga-	failure to learn from the incident in spite of a root cause analysis. In a large acute hospital, a patient	8-2016		is promoted by the WHO, ¹ the English National Health Service, ² the Institute	and QL. Possibly the most famous '5 whys' case	2016-0
Correspondence to Dr Mohaevrad Farhad Peesilly, SAPTHORE, Department of	tion of serious incidents, 1-3 is root cause analysis (RCA). Broadly understood as a	underwent a routine cataract surgery-an operation with a minimal risk profile-led	-00551		for Healthcare Improvement, ¹ the Joint Commission ⁴ and many other organisa-	study to be used in this way focuses on efforts to preserve the Washington Monument, ¹² ¹³ Details vary slightly	05840
Health Sciences, University of Lexander, Centre for Medicine University, Road Lexender, 121 78Y UK; wholeGin.ac.uk	method of structured risk identification and management in the aftermath of adverse events, ¹ RCA is not a single tech-	by an experienced ophthalmologist. The wrong lens was inserted during the oper- ation. The error was promotly recognised	an 23		tions in the field of healthcare quality and safety. Like most such tools, though, its popularity is not the result of any evi-	depending on the source, but it usually looks something like this:	49 on 2 Se
Accepted 20 May 2016 Published Online Tind	nique. Rather, it describes a range of approaches and tools drawn from fields	postoperatively; the patient was returned to the operating room and the procedure	June 20		dence that it is effective. ⁵⁻⁸ Instead, it probably owes its place in the curriculum and practice of RCA to a combination of	Problem: The Washington Monument is deteriorating Why? Harsh chemicals are being used to	2 September 2016, Dow
20 June 2016	including human factors and safety science ^{4,3} that are used to establish how and why an incident occurred in an	was safely redone. A subsequent root cause analysis identi- fied that two lenses were in the operating	n n		and practice of RCA to a combination of pedigree, simplicity and pedagogy. In terms of pedigree, '5 whys' traces its	Why? Harsh chemicals are being used to clean the monument Why? The monument is covered in pigeon	2016
	attempt to identify how it, and similar problems, might be prevented from hap-	room, one (the wrong one) brought in by an operating department assistant and the	ritede		roots back to the Toyota Production System (TPS). ⁹ It also plays a key role in Lean ¹⁰ (a generic version of TPS) as well	deoppings Why? Pigcons are attracted by the large number of spiders at the monument.	Downto
	pening again. ⁶ In this article, we propose that RCA does have potential value in healthcare, but it has been widely applied	other by the surgeon. The investigation report identified that having more than one lens in the operating room and a	h		as Six Signa, ¹¹ another popular quality improvement (QI) methodology. Taiichi	maniber of spiders at the monament Why? Spiders are annacred by the large namber of midges at the monament	aded to
	without sufficient attention paid to what makes it work in its contexts of origin,	failure in the double-checking process had caused the incident. The action plan			Ohno describes '5 whys' as central to the TPS methodology:	Why? Midges are attracted by the fact that the monument is first to be lit at night. Solution: Turn on the lights one bear later.	40
	and without adequate customisation for the specifics of healthcare, ^{7 8} As a result, its potential has remained under-realised ²	included the development of a new proto- col emphasizing the individual responsibil- ity of the surgeon to select the appropriate	all your and the second		The basis of Toyota's scientific approach is to ask why five times whenever we find a problem Be repeating why five	Solution: furn on the lights one toor fater. This is a great teaching example because the 'root cause' is so unintuitive.	1
	and the phenomenon of organisational forgetting' remains widespread (box 1). Here, we identify eight challences facing	lens, a training programme, improved documentation and a poster emphasising the importance of double checks.	land in		times, the nature of the problem as well as its solution becomes clear. The solu-	Who would think, before exploring the issue in depth, that lighting choices could endanger a mathle monument? But, as is	Sufey.
	the usage of RCA in healthcare and offer some proposals on how to improve learn-	One year later, in the same hospital, a different patient with a different surgeon	Out of		tion, or the how-to, is designated as '1H.' Thus, 'Five whys equal one how' (3W=1H). (ref. 9, p. 123)	so often the case, reality is messier than this simple illustration.	and one
	ing from incidents.	had the same procedure. Once again, the wrong lens was implanted. This time, the staff member who chose the wrong lens	March 6		This quote also makes the case for the technique's simplicity. Asking 'why' five	Joel Gross ¹² investigated the founda- tion of this example and discovered that many of the details are incorrect. And,	on Ma
Linked	The unhealthy quest for 'the' root cause The first problem with RCA is its name.	was the surgeon.	1, 2023		times allows users to arrive at a single root cause that might not have been obvious at the ourset. It may also inspire	crucially, the broader story it tells is incomplete.	10h 8, 2
Imiga-2014-005991 Imiga-2014-005991 Imiga-2014-005991 Imiga-2014-005229	By implying—even inadvertently—that a single root cause (or a small number of causes) can be found, the term 'root	displaces more complex, and potentially	and Aq		a single solution to address that root cause (though it is not clear that the '1H'	In terms of the story's details, the monument is question was actually the Lincoln Memorial, and it was not being	14 620
CrossMark	cause analysis' promotes a flawed reduc- tionist view." Incident investigation in the aftermath of an adverse event is	fruitful, accounts of multiple and inter- acting contributions to how events really unfold. ^{7 10-12} This is a tendency exacer-	L Prote	CrossMark	side of the equation has been adopted as widely).	damaged by the use of harsh chemicals. The real culprit was simply water.	guest. F
The obst. Prevails WE. Carr S.	the aftermath of an adverse event is intended to identify the latent and active factors contributing to the genesis of a	unfold. This is a tendency exacer- bated by use of some RCA techniques (such as timelines or the 'five whys') that	No los	•	'S WHYS' AS A TEACHING TOOL The pedagogical argument for 'S whys' is	Pigeoms were not an issue at all, and while there were 'tiny spiders' (ref. 14, p. 8) at the memorial, they were not a	Protected by
10 CBC Pressing lan, Carrs, Waring I, et al. 1947 Qualitar 2017;28:417-432.	particular adverse event,4 but too often results in a simple linear narrative that	tend to favour a temporal narrative rather than a wider system view.	** e	To cite: Card Al. BMJ (Quil) Sul 2017; 26:071-677.	The pedagogical argument for '5 whys' is that it creates an 'aha moment' by reveal- ing the hidden influence of a distant	p. 8) at the memorial, they were not a major problem. Instead, most of the cleaning was necessary because swarms of	d by o

investigation process as the only available option for learning from incidents resulting in harm"



PSIRF is a movement

- PSIRF is NOT an investigation framework
- Serious Incidents no longer feature
- Advocates a coordinated data-driven approach to learning and improvement
- Embeds patient safety incident response within a wider system of improvement
- Prompts a move away from a reactive and bureaucratic approach to safety towards systematic safety management
- Supports a significant shift in safety culture
- Testing and revision has been a formal part of the development cycle





Achieving effective learning and improvement



COMPASSIONATE ENGAGEMENT & INVOLVEMENT OF THOSE AFFECTED BY PATIENT SAFETY INCIDENTS

- Distinction: engagement and involvement
- Includes both families and staff affected



APPLICATION OF A RANGE OF SYSTEM BASED APPROACHES TO LEARNING FROM PATIENT SAFETY INCIDENTS

RCA no longer recommended 'Window on the system'



CONSIDERED AND PROPORTIONATE RESPONSES TO PATIENT SAFETY INCIDENTS

Planning

•

•

Stakeholder involvement



SUPPORTIVE OVERSIGHT FOCUSED ON STRENGTHENING RESPONSE SYSTEM FUNCTIONING AND IMPROVEMENT

- Emphasis on collaboration
- Decisions made together
- Non-hierarchical



42 | <u>NHS England » Patient Safety Incident Response Framework</u>



PSIRF Preparation Guide (Aug 2022)

Plan on a page

Month→ Phase↓	0 Aug-22	1 2 Sep-22 0	ct-22	3 Nov-22	4 Dec-22	5	6 Feb-23	7 Mar-23	8 Apr-23	9 May-23	10 Jun-23	11 Jul-23	12 Aug-23	13 Sep-23	14 Oct-23	15 Nov-23	16 Dec-23	17 Jan-24	18 Feb-24	19 20 Mar-24 Apr-24
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3	Governance and quality monitoring															0		JING TO LEARN &		
4	Patient safety incident response planning															EVOLVE OVI	ER FUTURE YEARS			
5											and agreement						V			
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7																	Embedding s	ustainable o	hange and ir	mprovement
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Month		Months 1-3			Months 4-7			Months 6-9			Months 7-10			Months 9-12	- 1		Months 12-16	;	Months 15 onwards	
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With thanks to: Wendy Halliburton, North Tees and Hartlepool NHS Foundation Trust

Find out more





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