D2: Improving services following adverse events

International Forum on
QUALITY & SAFETY
in HEALTHCARE
COPENHAGEN

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

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Institute for Healthcare Improvement

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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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Newcastle upon Tyne NHS Foundation Trust

International Forum on Quality and Safety in Healthcare

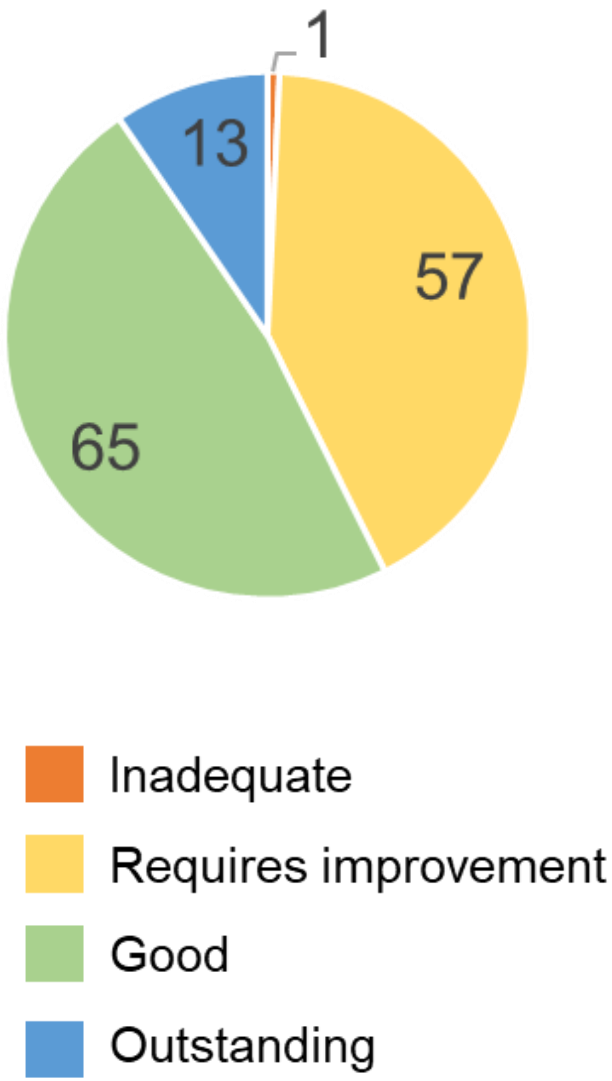
Copenhagen

17 May 2023

CareQuality Commission

NHS Digital

CQC ratings - Overall



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

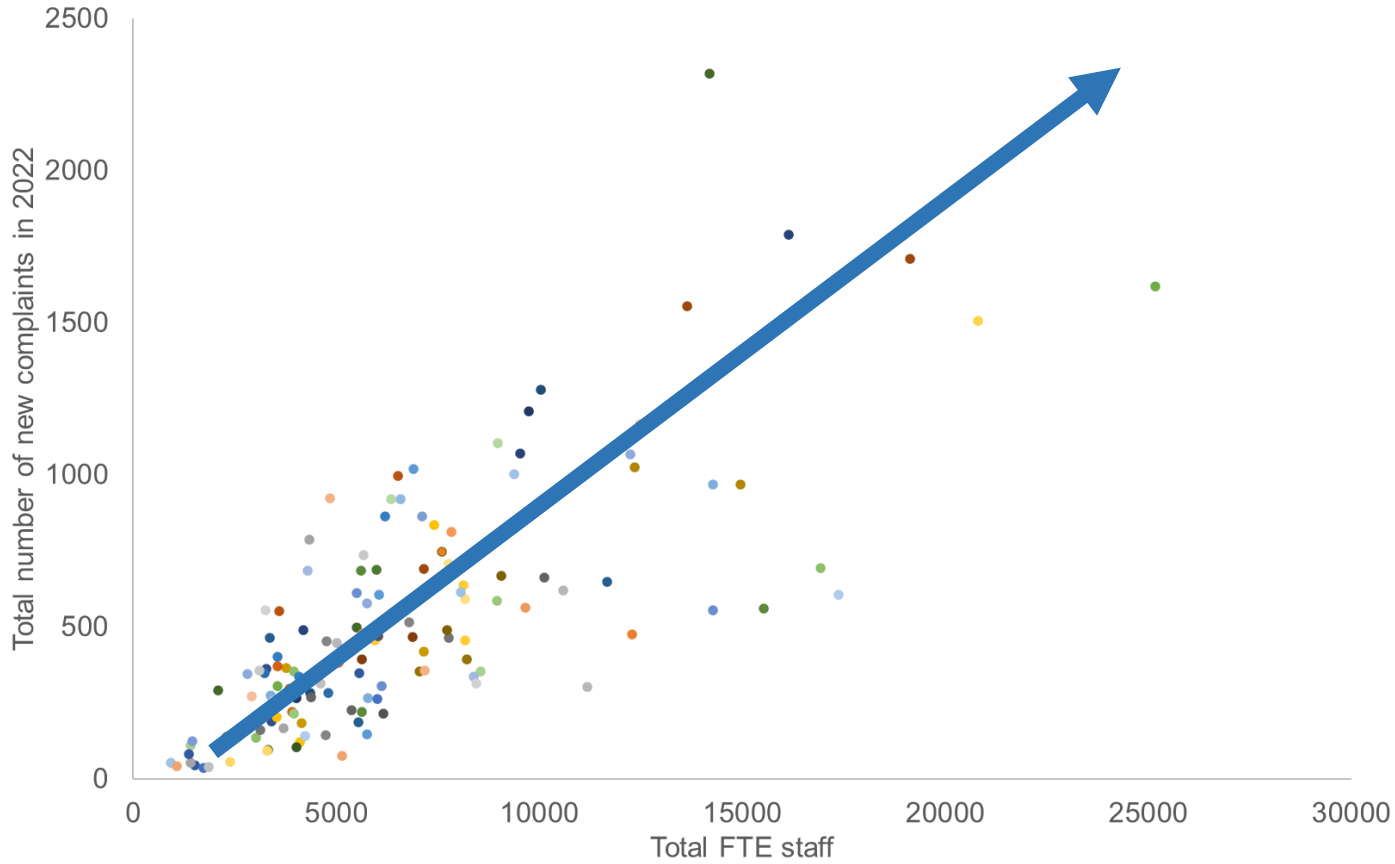
Complaints (2021-2022) = 105,506
Complaints in NHS hospitals = 70,083

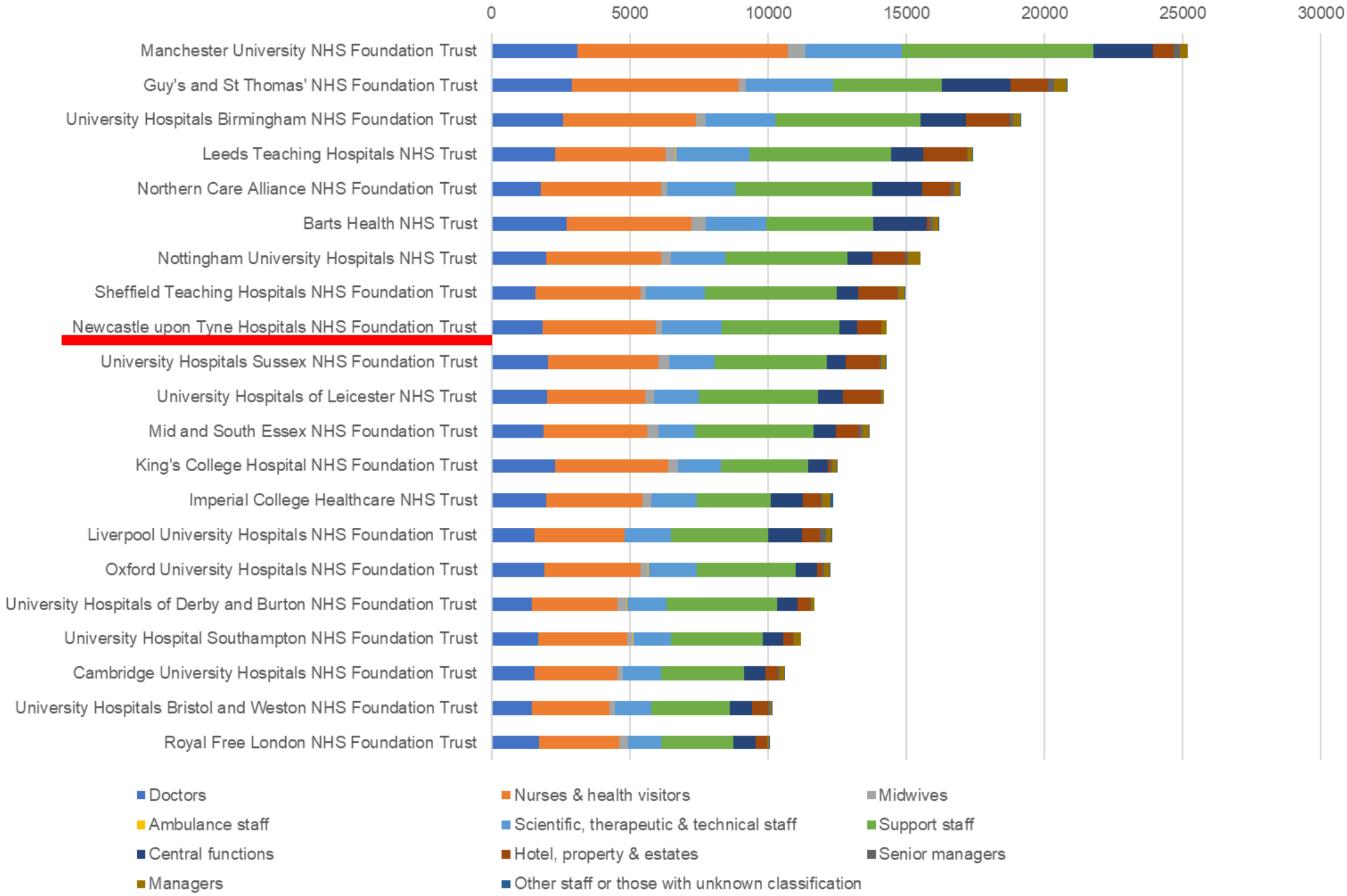
MOST COMPLAINTS

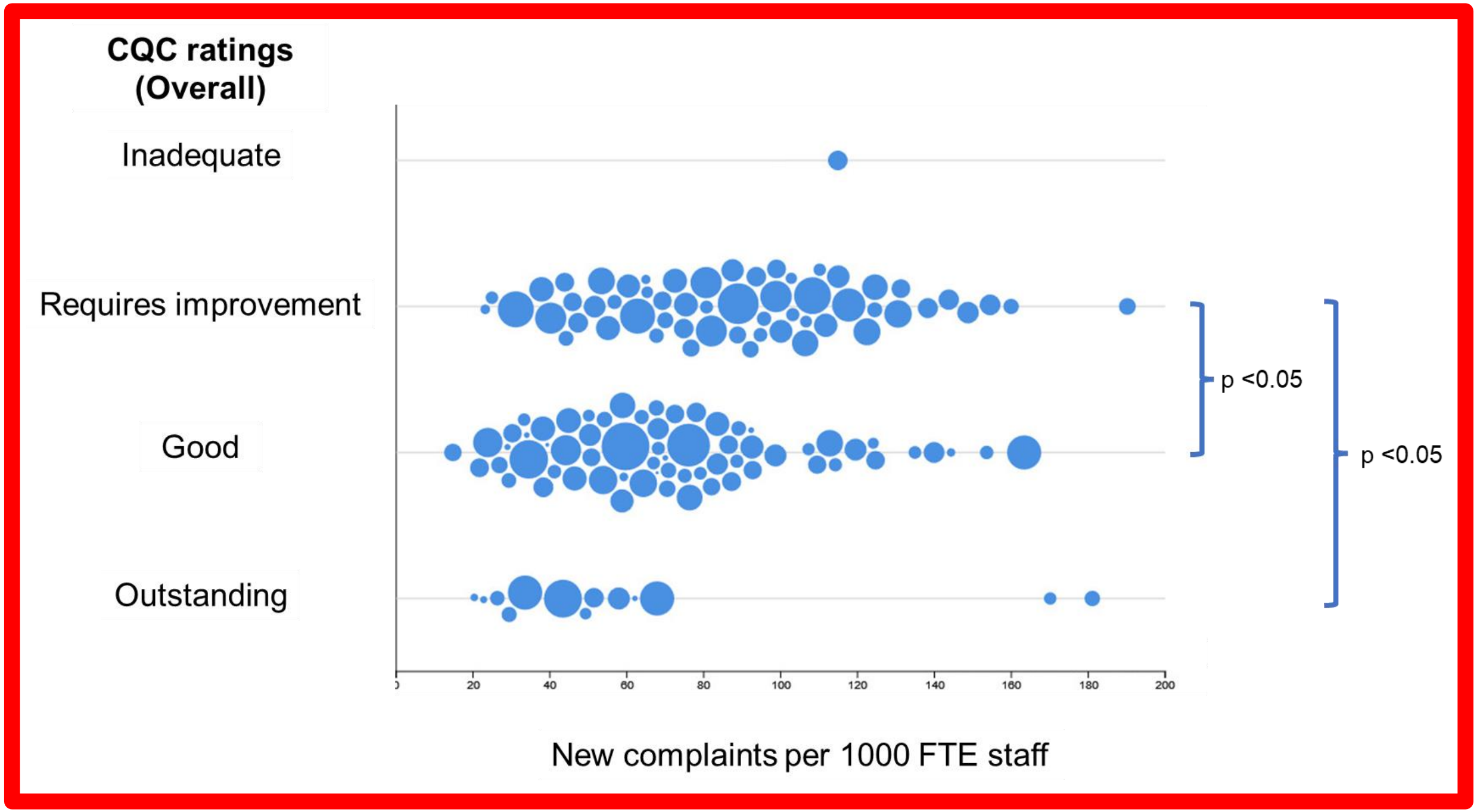
1. University Hospitals of Leicester NHS Trust (n=2,319)
2. Barts Health NHS Trust (n=1790)
3. University Hospitals Birmingham NHS Foundation Trust (n=1709)
4. Manchester University NHS Foundation Trust (n=1,619)
5. Mid and South Essex NHS Foundation Trust (n=1,555)

LEAST COMPLAINTS

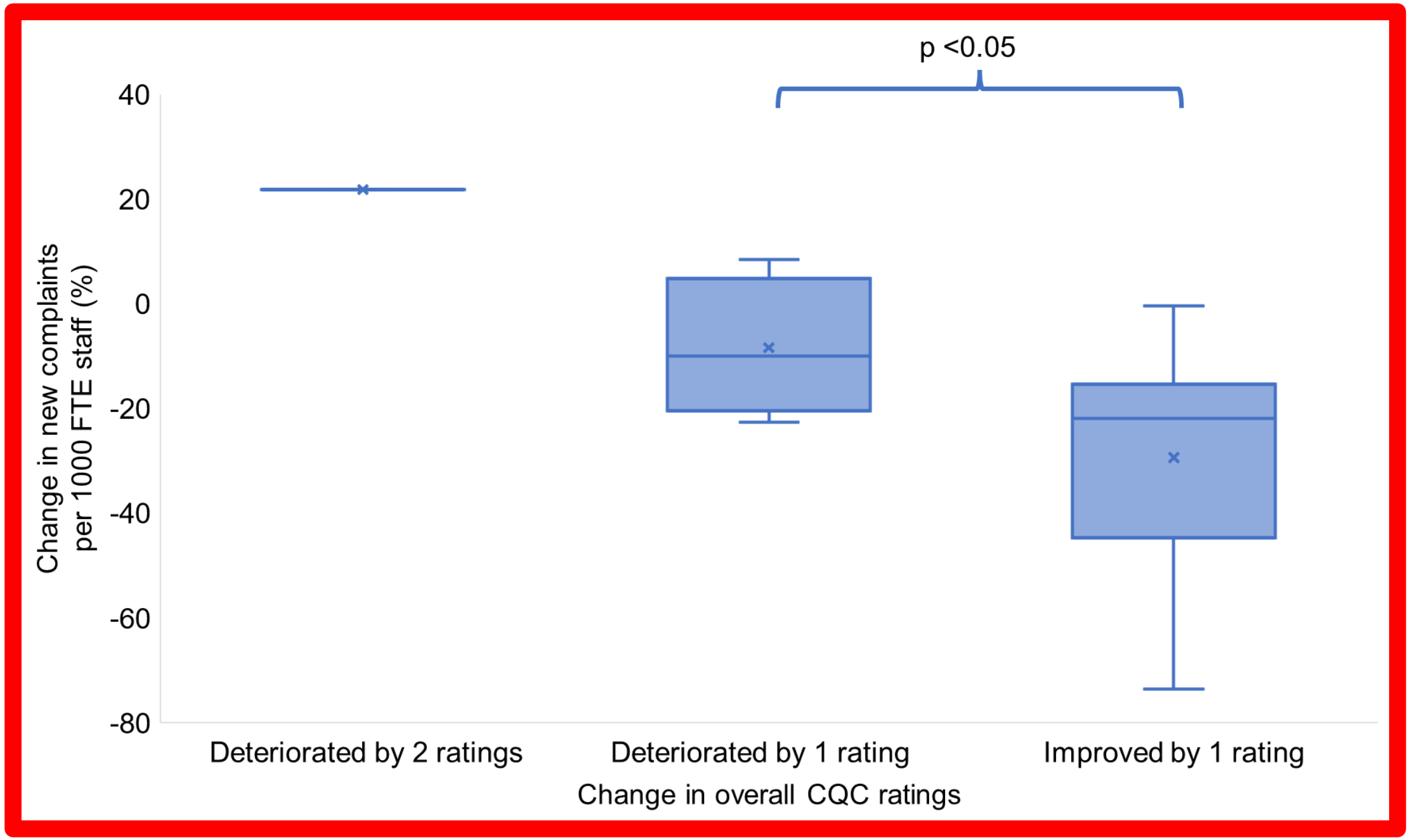
1. Liverpool Heart and Chest Hospital NHS Foundation Trust (n=38)
2. Royal Papworth Hospital NHS Foundation Trust (n=39)
3. Royal Orthopaedic Hospital NHS Foundation Trust (n=43)




0
5000
10000
15000
20000
25000
30000
Manchester University NHS Foundation Trust
Guy's and St Thomas' NHS Foundation Trust
University Hospitals Birmingham NHS Foundation Trust
Leeds Teaching Hospitals NHS Trust
Northern Care Alliance NHS Foundation Trust
Barts Health NHS Trust
Nottingham University Hospitals NHS Trust
Sheffield Teaching Hospitals NHS Foundation Trust
Newcastle upon Tyne Hospitals NHS Foundation Trust
University Hospitals Sussex NHS Foundation Trust
University Hospitals of Leicester NHS Trust
Mid and South Essex NHS Foundation Trust
King's College Hospital NHS Foundation Trust
Imperial College Healthcare NHS Trust
Liverpool University Hospitals NHS Foundation Trust
Oxford University Hospitals NHS Foundation Trust
University Hospitals of Derby and Burton NHS Foundation Trust
University Hospital Southampton NHS Foundation Trust
Cambridge University Hospitals NHS Foundation Trust
University Hospitals Bristol and Weston NHS Foundation Trust
Royal Free London NHS Foundation Trust
Doctors
Nurses & health visitors
Midwives
Ambulance staff
Scientific, therapeutic & technical staff
Support staff
Central functions
Hotel, property & estates
Senior managers
Managers
Other staff or those with unknown classification

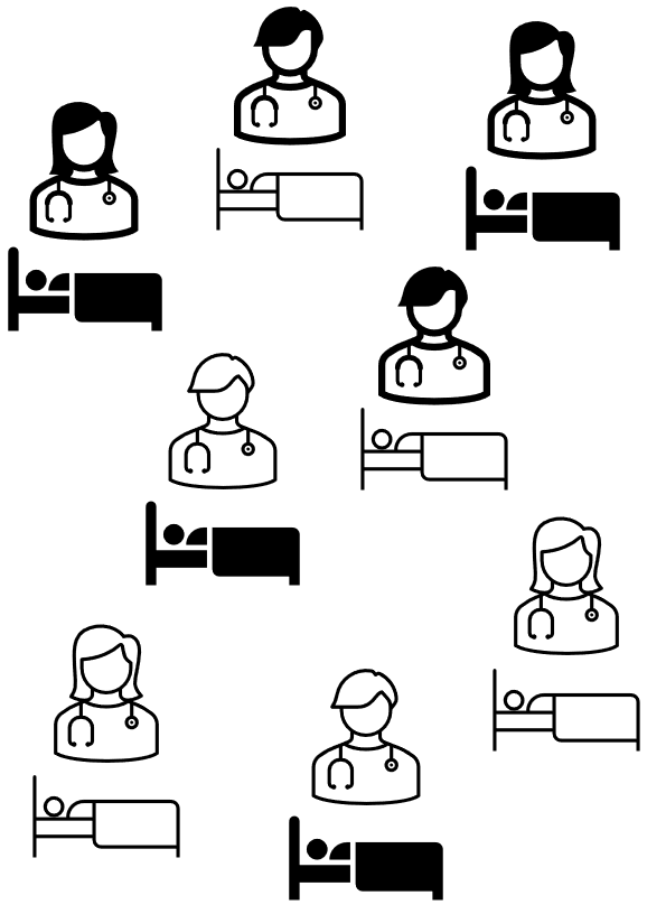

CQC ratings (Overall)
Inadequate
Requires improvement
Good
Outstanding
0
20
40
60
80
100
120
140
160
180
200
p <0.05
p <0.05
New complaints per 1000 FTE staff

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


p <0.05
40
20
0
-20
-40
-60
-80
Change in new complaints per 1000 FTE staff (%)
Deteriorated by 2 ratings
Deteriorated by 1 rating
Improved by 1 rating
Change in overall CQC ratings

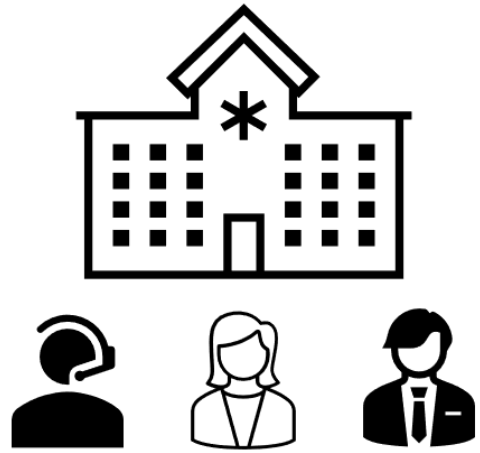

0
10
20
50
60
70
COMPLAINTS

AGENT ROLE:
Departments within the hospitals



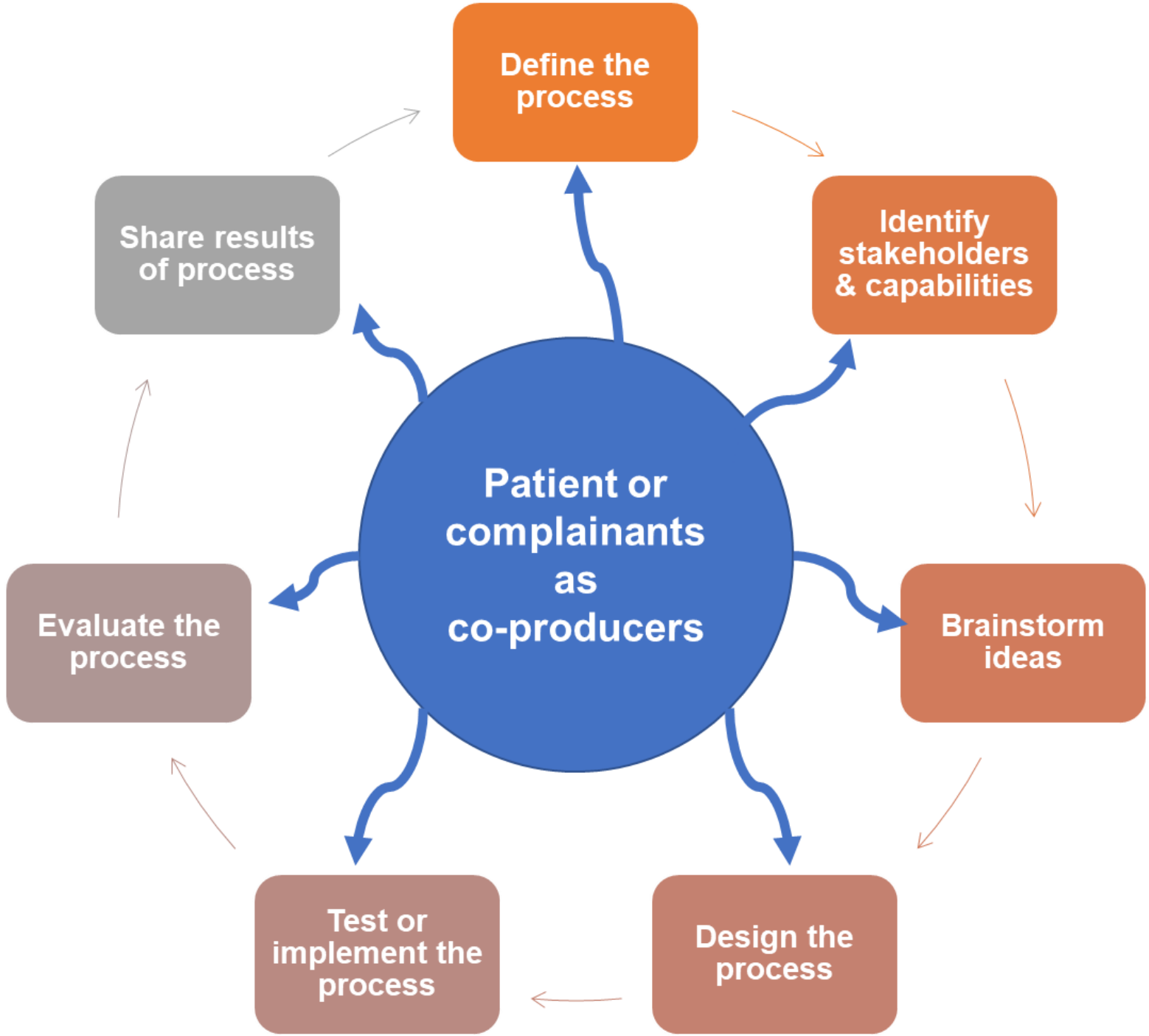
Regular reporting of patient complaints as an early indicator of clinical performance

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
1	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
2	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


Define the process
Identify stakeholders & capabilities
Brainstorm ideas
Design the process
Test or implement the process
Evaluate the process
Share results of process
Patient or complainants as co-producers

THE great north CHILDREN'S HOSPITAL

NHS
The Newcastle upon Tyne Hospitals
NHS Foundation Trust

wellcome centre mitochondrial research

Newcastle University

Northumbria University NEWCASTLE

Thank you for listening

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NHS
Health Education England




Rigshospitalet

Learning from Patient and Relative Reported Adverse Events

Mark Krasnik

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Rigshospitalet University Hospital Copenhagen

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

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

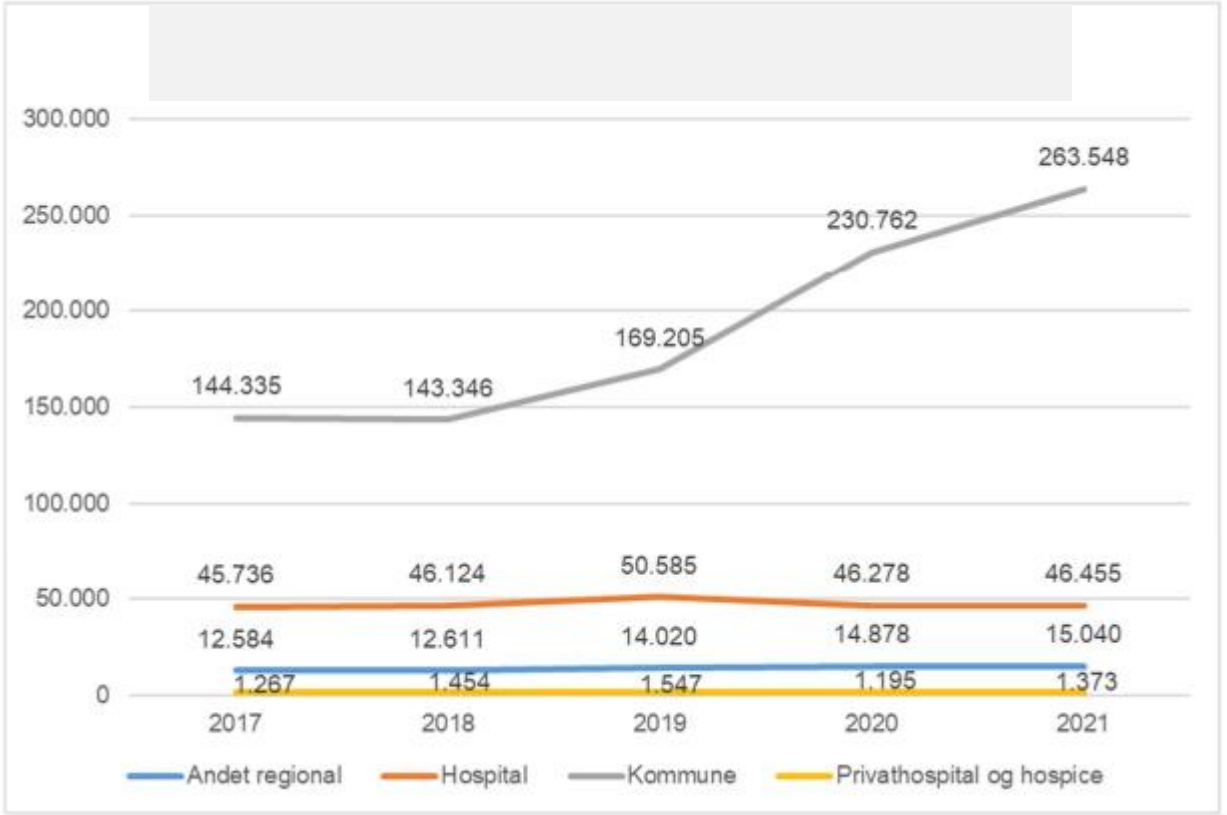
A patient or a relative may report an unintended incident to a region, municipality or private hospital,

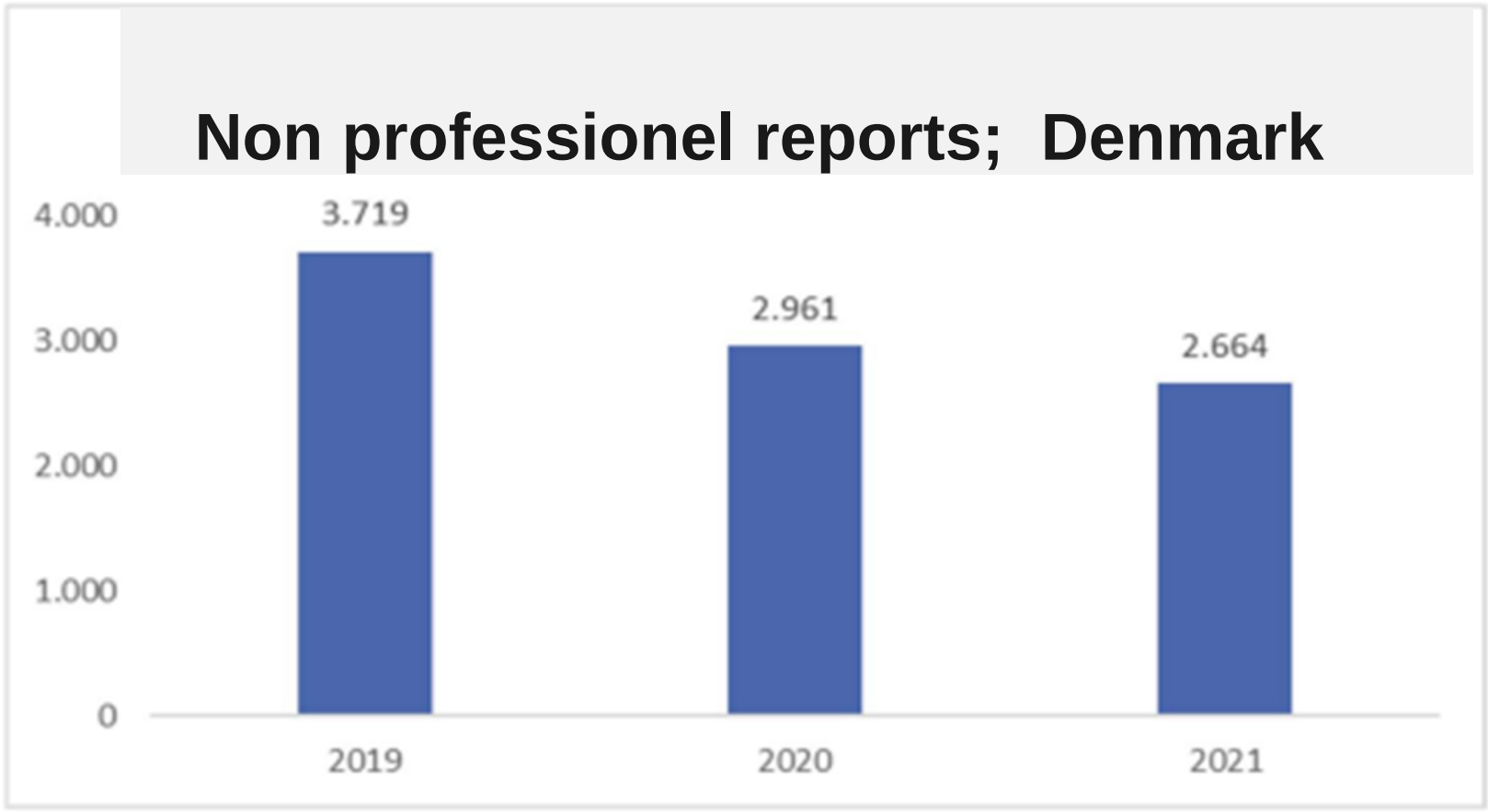
There is no time limit for reporting from patients or their relatives.

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

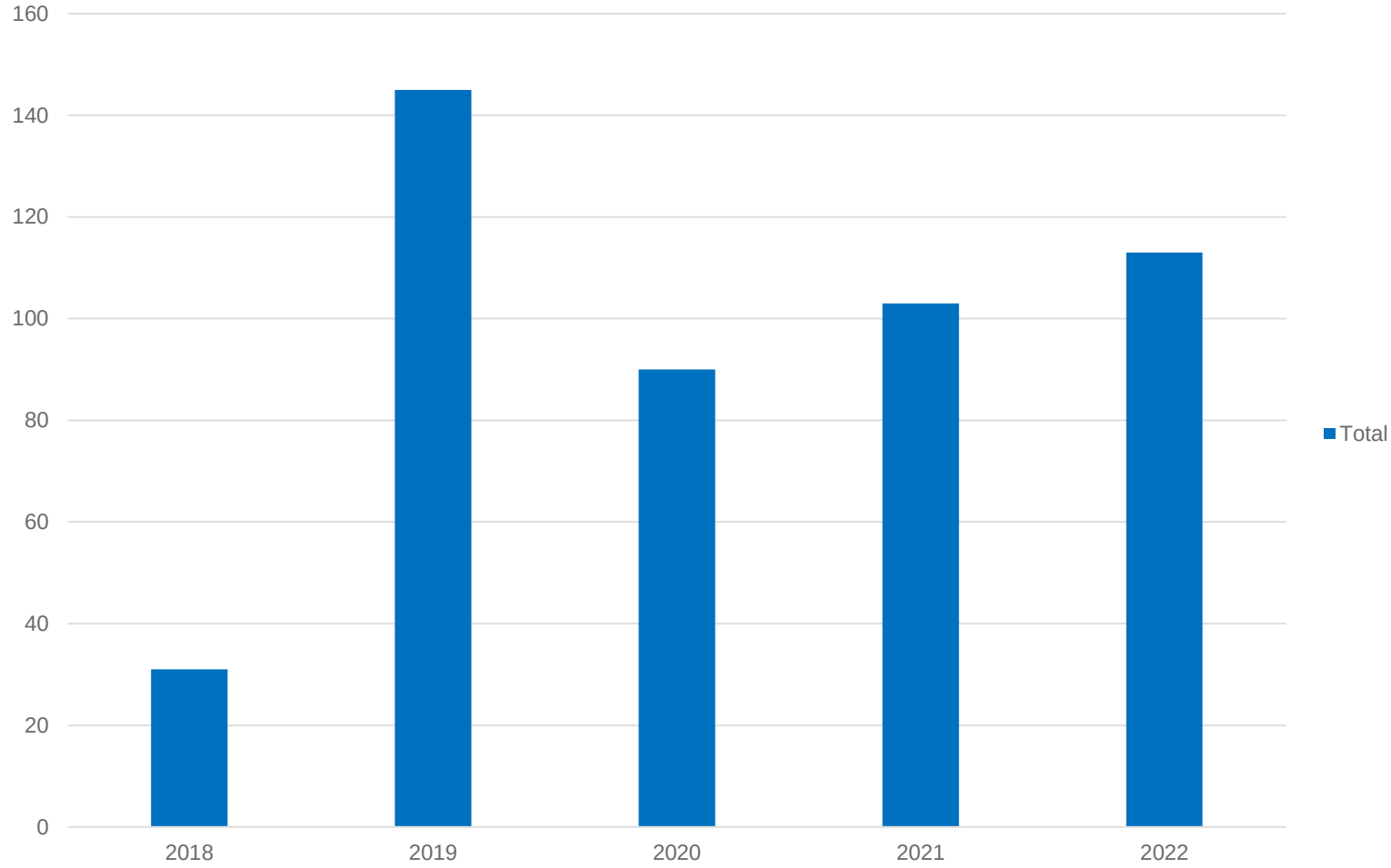
Rapported Adverse events 2017 -2021 Denmark Who reports ?



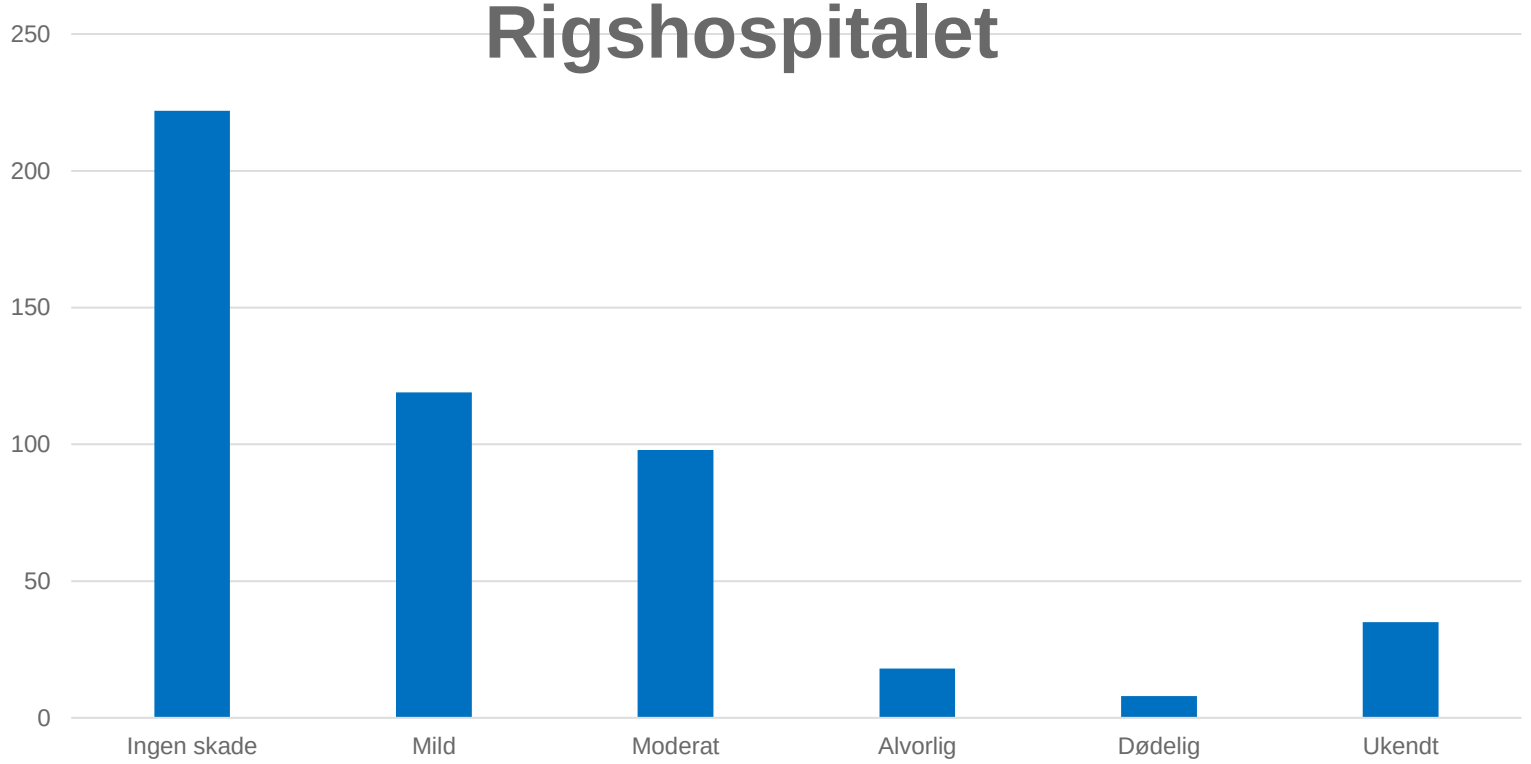


Figur 11. Antal rapporterede utilsigtede hændelser rapporteret af patienter og pårørende i perioden 2019-2021

Non professionel reports; Rigshospitalet



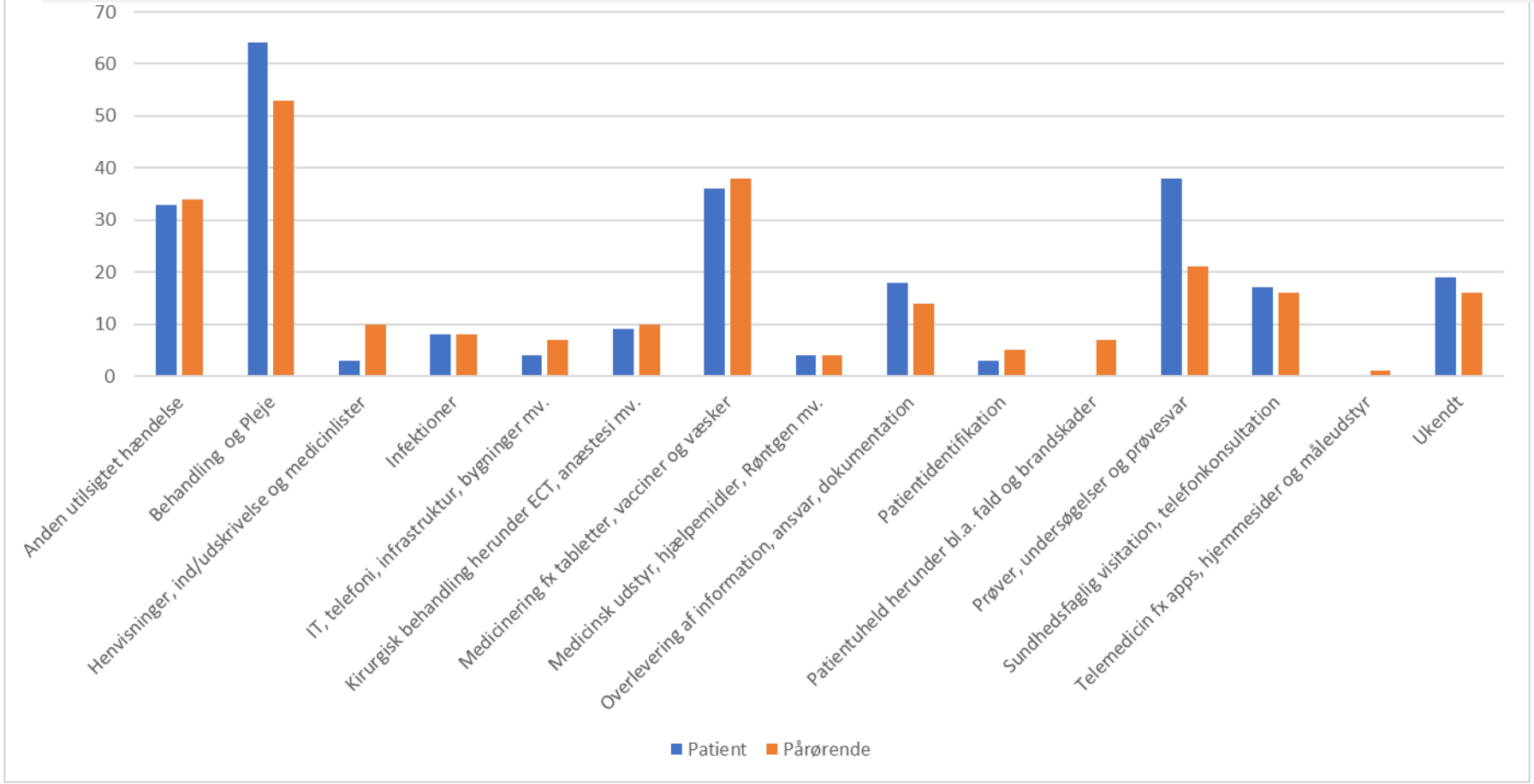
Numbers of adverse event scoring Rigshospitalet



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

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

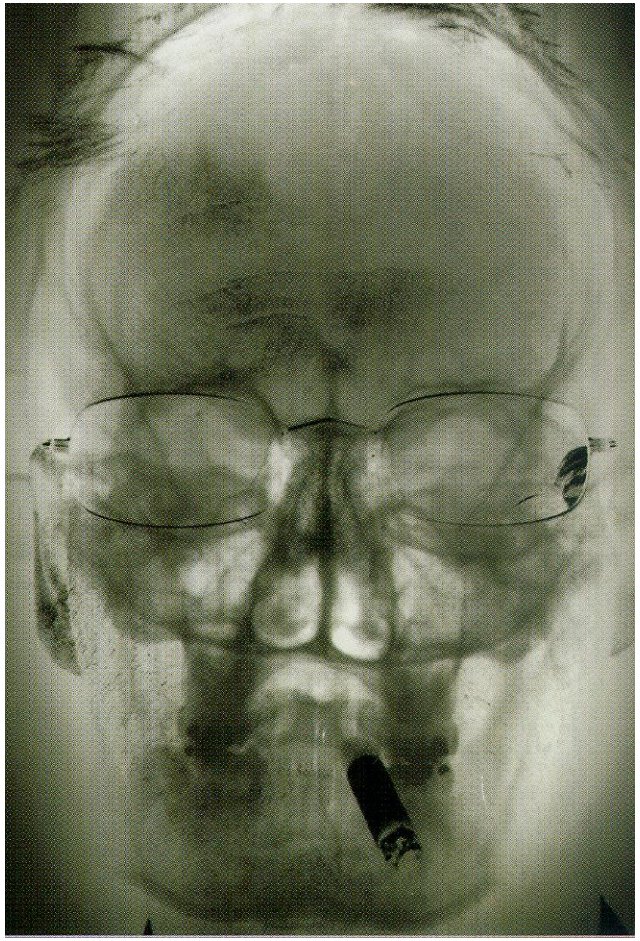
b. Reports shows relatives' lack of understanding that in several contexts it is the patient who decide the choice and level of treatment And who should be contacted as well as what information must be shared

c. Health care personals failure to respond to symptoms

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.

- You have reached your destination”



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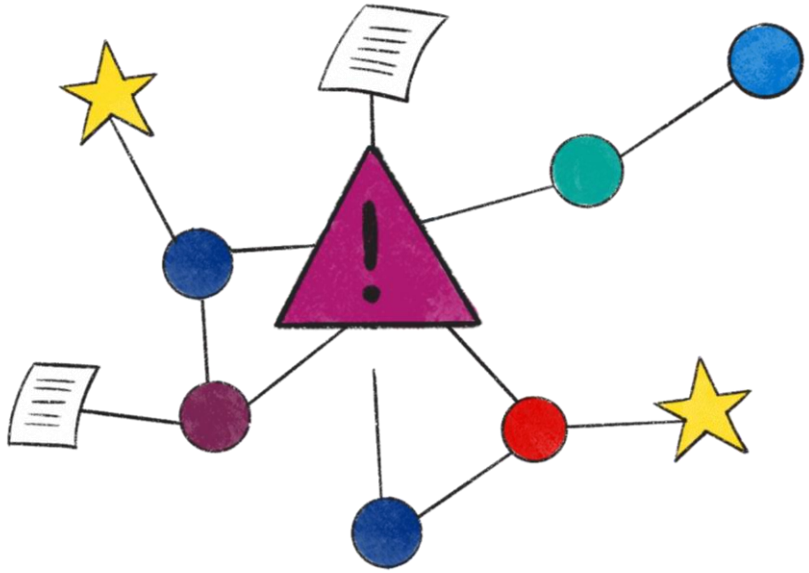


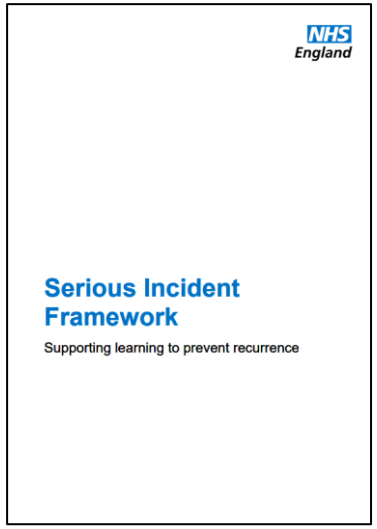
Improving more by investigating less: rethinking patient safety incident response

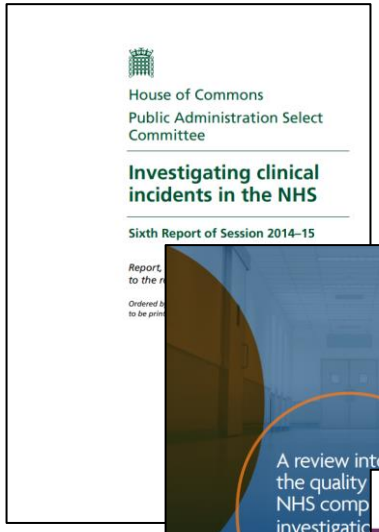
International Forum on Quality and Safety in Healthcare, Weds 17 May

✉ tracey.herlihey@nhs.net; laurenmosley@nhs.net; matthew.fogarty@nhs.net

@traceyherlihey @Lauren_e_Mosley @safety_matt

Policy context

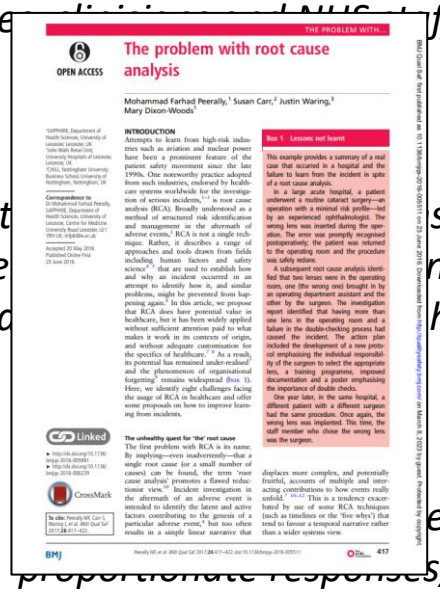


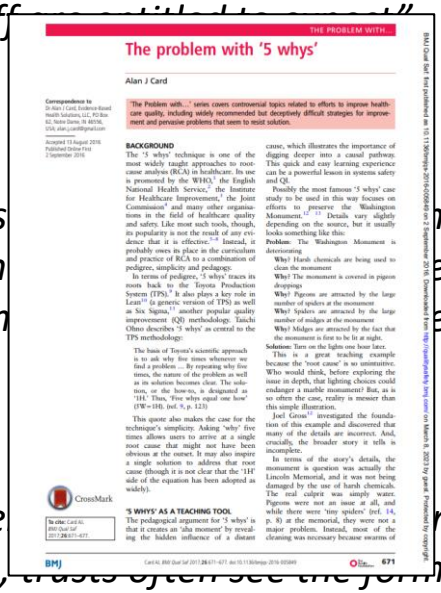


"The Framework aims to facilitate learning by promoting a fair, open, and just culture that abandons blame as a tool and promotes the belief that 'incidents cannot simply be linked to the actions of the individual healthcare staff involved but rather the system in which the individuals were working'"

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

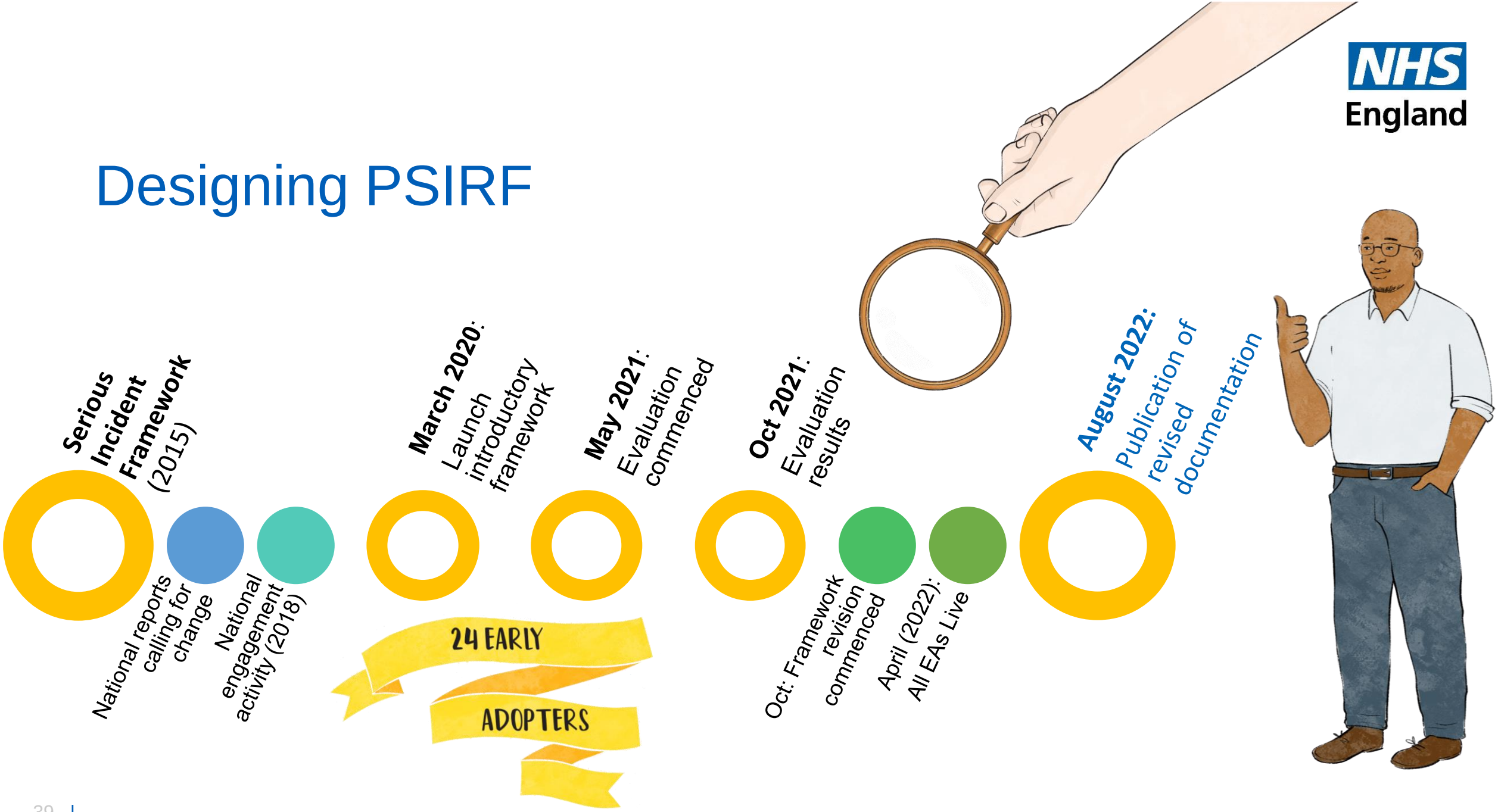
"We found t *nd out what happe* *ey are also not find* *e"*





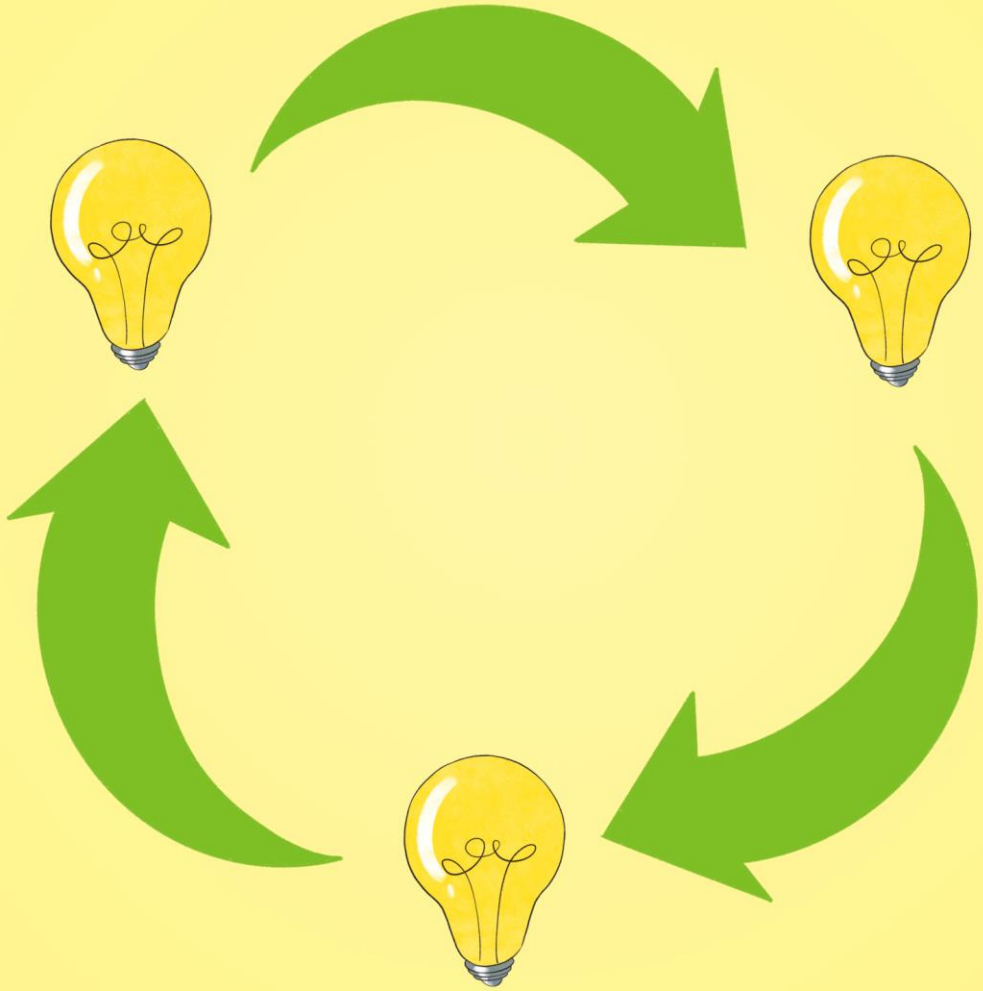
more proportionate responses, trusts often see the formal investigation process as the only available option for learning from incidents resulting in harm"

Designing PSIRF



PSIRF is a movement

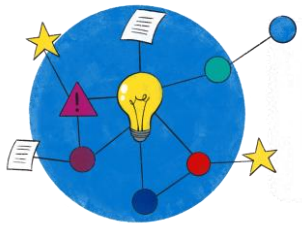
- PSIRF is NOT an investigation framework
- Serious Incidents no longer feature
- Advocates a coordinated data-driven approach to learning and improvement
- Embeds patient safety incident response within a wider system of improvement
- Prompts a move away from a reactive and bureaucratic approach to 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

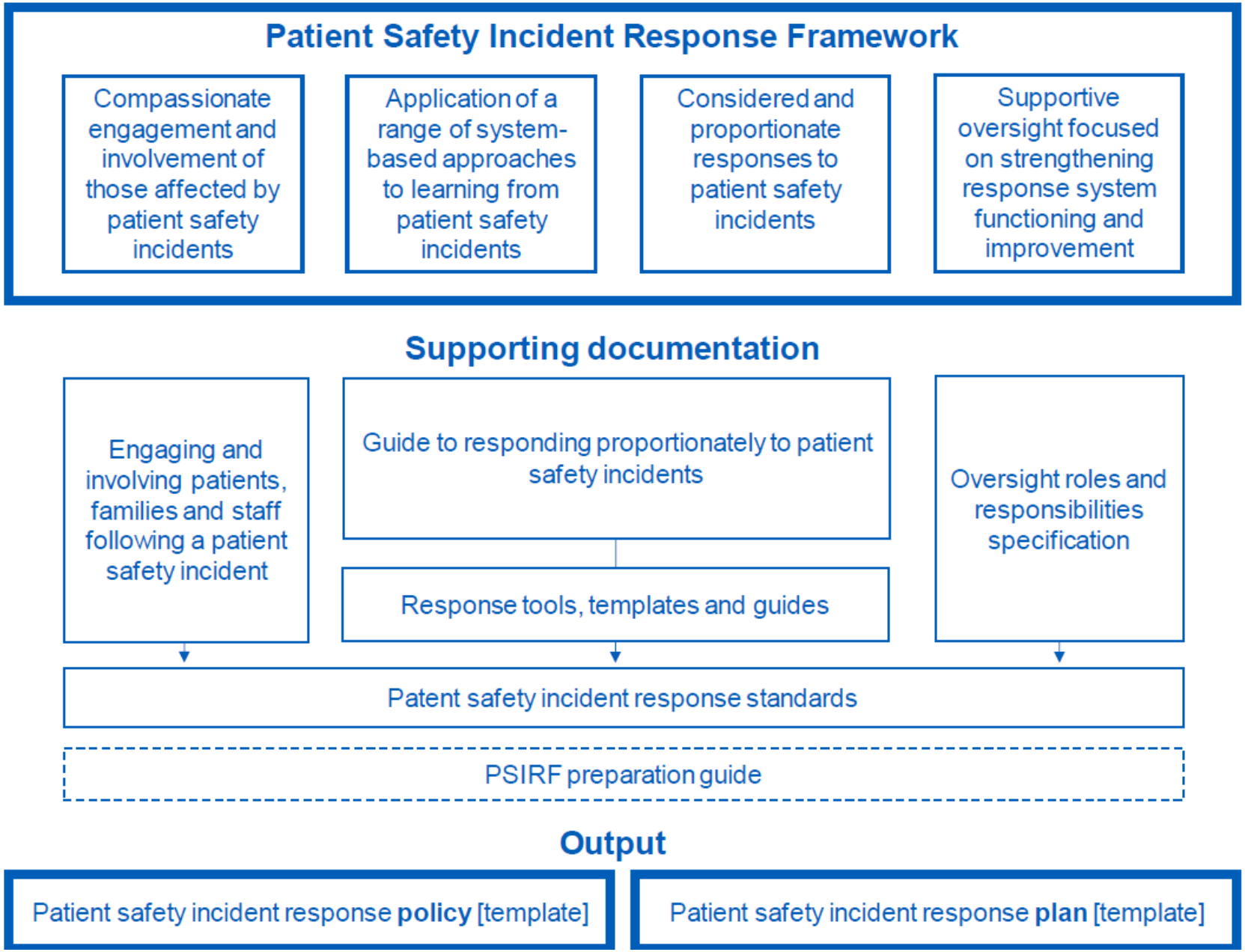
- RCA no longer recommended
- 'Window on the system'

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


Patient Safety Incident Response Framework
Compassionate engagement and involvement of those affected by patient safety incidents
Application of a range of system-based approaches to learning from patient safety incidents
Considered and proportionate responses to patient safety incidents
Supportive oversight focused on strengthening response system functioning and improvement
Supporting documentation
Engaging and involving patients, families and staff following a patient safety incident
Guide to responding proportionately to patient safety incidents
Response tools, templates and guides
Oversight roles and responsibilities specification
Patent safety incident response standards
PSIRF preparation guide
Output
Patient safety incident response policy [template]
Patient safety incident response plan [template]

PSIRF Preparation Guide (Aug 2022)
Plan on a page

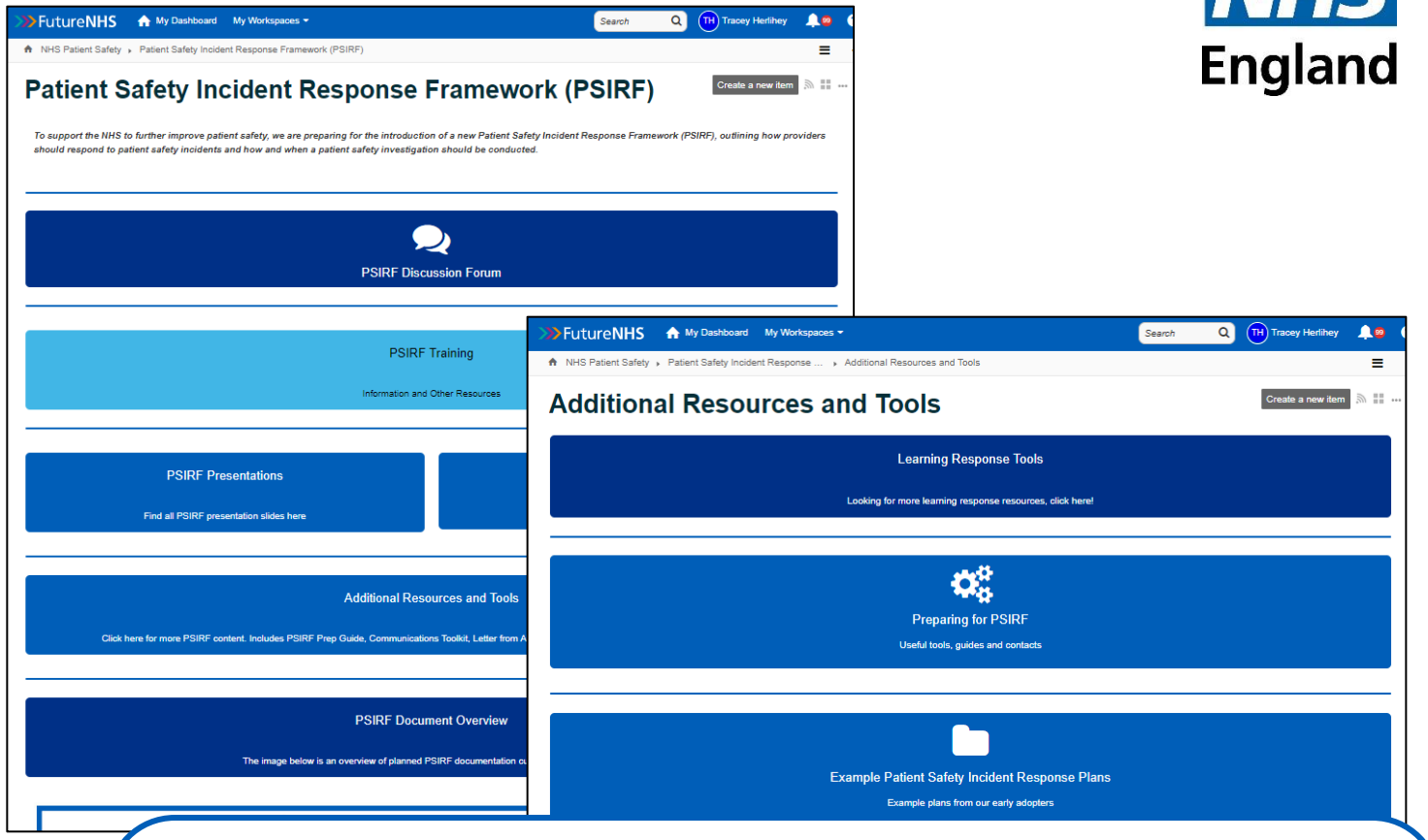
Month →	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
Phase ↓	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
1	PSIRF orientation																				
2					Diagnostic and discovery																
3							Governance and quality monitoring														
4								Patient safety incident response planning													
5										Curation and agreement of the patient safety incident response policy and plan											
6													Transition – working under the patient safety incident response policy and plan								
7																Embedding sustainable change and improvement					

Phase	1. Orientation		Diagnostic & discovery		Governance & quality		PSIRP		Draft policy & plan		Transition		Embedding	
Month	Months 1-3		Months 4-7		Months 6-9		Months 7-10		Months 9-12		Months 12-16		Months 15 onwards	
Actions	1.1	Create an implementation team	2.1	What is being done to support open and transparent reporting?	3.1	Develop processes for incident response decision making	4.1	Map your services	5.1	Populate the policy and plan templates and sahre these with stakeholders	Here be dragons.....			
	1.2	Allocate time for reading and reflection	2.2	How do you engage and involve those affected by patient safety incidents?	3.2	Define how system effectiveness will be monitored	4.2	Examine patient safety incident records and safety data	5.2	Respond to stakeholder feedback on the draft policy and plan				
	1.3	Identify knowledge and support needs for getting started	2.3	What is being done to support the development of a just culture?	3.3	Develop processes for reporting cross-system issues	4.3	Describe the safety issues revealed by the data	5.3	Agree how to manage transition				
	1.4	Create a stakeholder list and plan engagement	2.4	What is your incident response capacity and what are your training needs?	3.4	Define how system effectiveness will be monitored	4.4	Identify work underway to address contributory factors	5.4	Ensure commitment to delivering required improvement				
	1.5	Agree structures and process for programme management	2.5	How do you use learning from incident responses to inform improvement?			4.5	Agree how you intend to respond to issues listed in your patient safety incident profile	5.5	Seek policy and plan approval / sign off and agree 'transition date'				
	1.6	Set ambition for PSIRF implementation	2.6	What do you need to do next?										

- PSIRF requires teams to adapt and implement new ways of working
- There is a need for relationship building and undoing entrenched habits

With thanks to: Wendy Halliburton, North Tees and Hartlepool NHS Foundation Trust

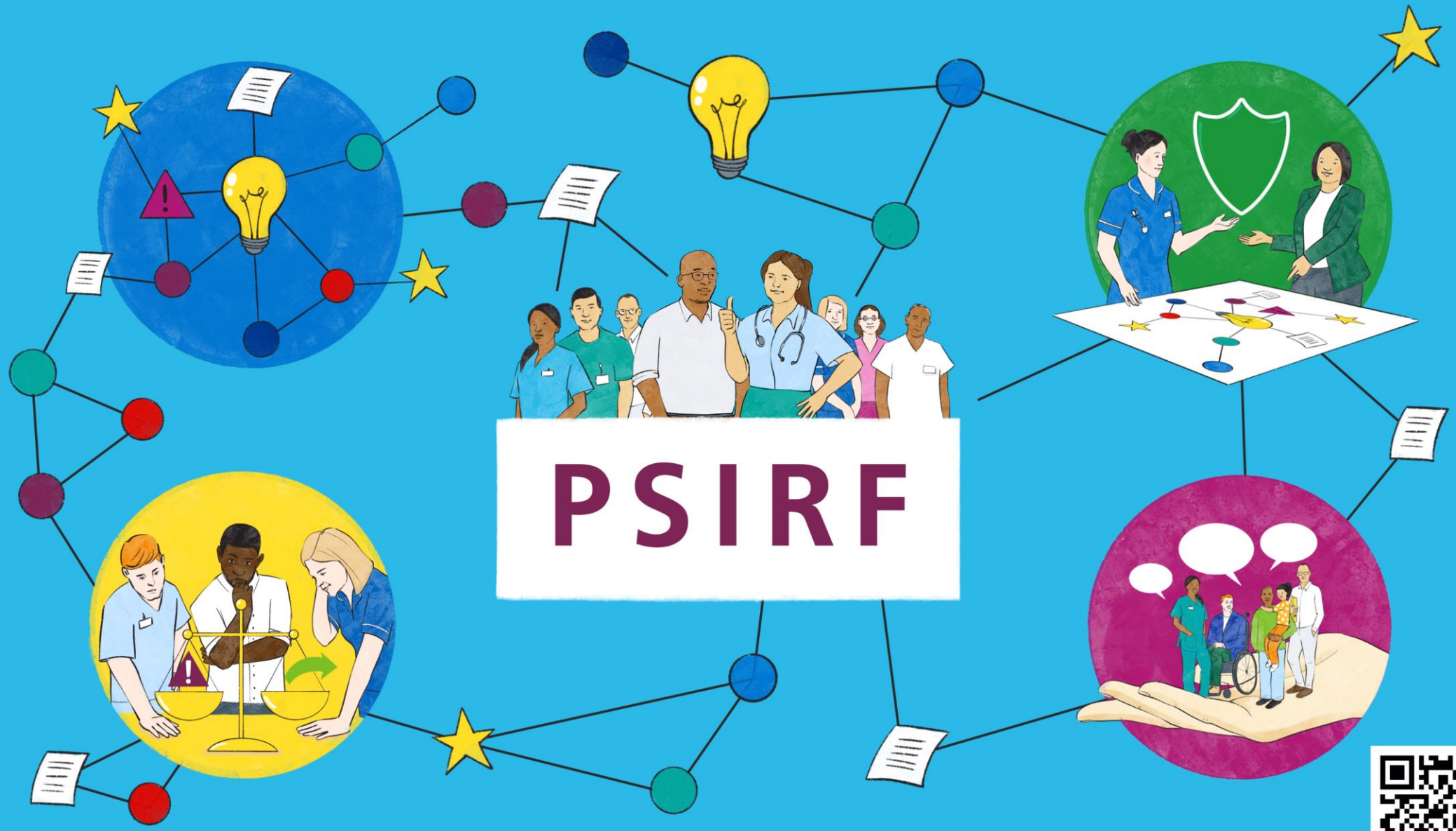
Find out more



The NHS patient safety workspace is open to all to access.

You do not need an NHS email address.

If you are not already a FutureNHS user, you can request access by emailing NHSps-manager@future.nhs.uk



If you'd like to find out more, visit:www.england.nhs.uk/patient-safety/incident-response-framework