White paper

Incident reporting systems: Future strategies for patient safety improvement

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There has been much global focus on improving patient safety in recent years but despite this, progress has been slow in many areas. Too often, healthcare organisations are still failing to learn from things that go wrong, meaning that the same mistakes are repeated.

As well as the importance of fostering the right culture, I have written previously about the importance of good risk management systems, processes and resources. This paper takes another look at some of the issues affecting culture and discusses the opportunities to improve patient safety through better collaboration between healthcare organisations. This paper also looks at the next steps for patient safety improvement, the changes that are still needed and the role that new technology can play.

Culture and psychological safety

The issue we return to again and again in reports, discussions or research on patient safety is culture. In previous papers I have outlined the importance of psychological safety: healthcare professionals must feel confident and secure in reporting errors and raising concerns knowing that they will be treated fairly. In the UK, optometrist Honey Rose[1] has been found guilty of gross negligence manslaughter as a result of failing to diagnose a fatal build-up of fluid in the brain of a young child. This heartbreaking case has sent shockwaves across the medical community, prompting an open letter and petition with over 4,000 signatures[2] calling on the Department of Justice to review the use of gross negligence manslaughter charges against healthcare professionals.

The case highlights the difficulties in balancing the need for accountability for intentional or reckless acts with the need to ensure that healthcare professionals are not punished for human error. These are both key components of a just culture.

Individual healthcare organisations must embrace a culture of open and honest disclosure. This is important to encourage incident reporting and investigation as opportunities for learning and improvement. Importantly, the wider system, including professional regulation and the criminal justice system, must also pull in the same direction.

Punishing unintentional mistakes leads to a culture of fear and can result in even more harm to patients. The Department of Health is currently considering its response to the Healthcare Safety Investigation Branch (HSIB) Expert Advisory Group (EAG) report[3], including the recommendation for there to be a 'Just Culture Taskforce' for the NHS. It is clear that more work in this area is needed and this must involve all part of the system that influence psychological safety.

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Using data to drive improvement

In his book 'Black Box Thinking', Matthew Syed states that "...many of the errors committed in hospitals have particular trajectories, subtle but predictable patterns; what accident investigators call 'signatures'. With open reporting and honest evaluation, these errors could be spotted and reforms put in place to stop them happening again..."

This neatly describes why incident reporting systems play an important role in managing safety, not just in healthcare, but in all safety critical sectors. They provide organisations with essential information about hazards and risks that may otherwise remain hidden and provide important opportunities to improve and make changes to protect patients from future harm.

At Datix we know that the effectiveness of incident reporting systems in supporting safer healthcare is influenced by a number of factors. These include:

1. Ensuring that healthcare staff feel safe in reporting incidents and raising concerns (psychological safety).
2. Systems and processes to assign and prioritise appropriate levels of investigation.
3. The right resources including experienced and appropriately trained incident investigators.
4. Systems and processes to ensure contributory factors are recognised and data can be effectively analysed to identify patterns and trends.
5. Systems and processes to ensure recommendations, interventions and improvement strategies are evidenced based, resource effective and implemented in a controlled manner.
6. Systems and processes to ensure improvement strategies and interventions are monitored and sustained.
7. Keeping staff informed of improvements and providing staff with feedback relating to how incidents and patient safety concerns have been addressed.

If any of these components break down, the effectiveness of reporting systems is diminished and staff can become disengaged and cynical about the purpose and value of reporting incidents and raising concerns.

We hear examples of clinicians who are reluctant to report all but the most serious of incidents because they feel reporting less serious incidents creates an administrative burden without resulting in tangible improvement. We need to ensure the process of reporting an incident is as easy as possible, but such views also mean it is vital that organisations have the right systems, processes and resources in place to ensure incident data is used to identify hazards and risks for further investigation, ultimately leading to change and improvement.

Organisations with good systems and processes should be able to play an important role in sharing their learning and experience with organisations that need to improve.

From competition to collaboration

NHS England's Five Year Forward View[4] sets out a future vision of increasing integration and collaboration between different NHS services. These plans are now taking shape with new models of care delivery including Multispecialty Community Providers (MCPs)

and integrated Primary and Acute Care Systems (PACS) now emerging. Last month NHS Improvement announced the first four acute trusts identified as being high performing organisations, accredited to support other organisations in improving patient services. These accredited organisations, known as Acute Care Collaboratives (ACCs), have great potential to help spread good practice. This move towards integration and collaboration brings other welcome opportunities to help improve patient safety.

In the recent book Safer Healthcare – Strategies for the Real World[5], Charles Vincent discusses the importance of seeing safety 'through the patient's eyes'. In the past, the view of what constitutes an incident has often been from the eyes of clinicians or healthcare professionals. However, a wider view of issues and opportunities to improve patient care can be gained by looking from the patient's perspective across the whole care pathway. From this perspective an incident could be harm caused by fundamental longer term failures, for example an avoidable hospitalisation due to undetected deterioration in a chronic condition. Closer integration of care services provides an opportunity to take this wider view and identify opportunities to improve patient care that could otherwise be missed.

NHS Improvement has published some of the successes resulting from the work of the fifteen Patient Safety Collaboratives[6] established following the 2013 Berwick Review[7]. The achievements include the development of care bundles that have reduced mortality following emergency laparotomies, establishing safety huddles that have significantly reduced inpatient falls and work that has reduced inpatient medication errors. Good work is also being done by the Sign Up to Safety campaign[8]. This work shows what can be achieved by working collaboratively across different organisations to share and spread learning, solutions and examples of excellence.

Although this is undeniably important, it is still too often the case that individual organisations are not sharing interventions and strategies they have developed locally. In his book, Charles Vincent proposes that we need to "...observe, identify and collate safety relevant strategies and interventions at all levels of healthcare organisations and the wider system..." and "...develop a more robust taxonomy of approaches and begin to assess which might be applicable in different contexts."

It is clear that future progress lies in this direction.

The changing landscape

The UK government has recently announced a range of measures for the NHS in England aimed at making further progress to support the development of a learning culture in order to reduce avoidable harm. These include:

- The establishment of national and local Freedom to Speak Up Guardians.
- The establishment of a new national Healthcare Safety Investigation Branch (HSIB) for England.
- Confirmation that the Medical Examiners system, a recommendation dating back to the report of the Shipman Inquiry (2003), will be fully rolled out across the NHS by April 2018[9].

The common thread connecting all these initiatives comes back again to culture.

In March 2016, Imperial College London and Imperial College Healthcare NHS Trust launched their joint report 'Patient Safety 2030'[10]. The report states:

Culture is often seen as a nebulous and non-quantifiable concept even though it can be defined – and thus measured and improved. Historically it has been under-researched and slow to emerge as a root cause

of adverse events. This lack of attention to culture is problematic, given the role it plays in fostering safety.

As discussed earlier in this paper, the levers that influence culture are system wide, with lasting progress dependent on ensuring all parts of the system pull in the same direction. This must include better support for patients involved in incidents and systems that ensure healthcare professionals are treated fairly when things go wrong.

Improving patient safety must also involve better use of the data we collect, moving from an understanding of 'what' goes wrong towards an understanding of 'why' and 'how'. Collating effective improvement strategies and interventions that have been assessed in different contexts and sharing this information across the system could help organisations focus on the most effective solutions. The effectiveness of recommendations that arise from investigations needs to be measured and monitored and improvement sustained.

Here at Datix, we believe that new technology will play an important role in the next steps of the patient safety revolution. The effective implementation of new technology will help the healthcare community use data intelligently to identify risks, gain a deeper understanding of why things go wrong and implement, monitor and share effective improvement solutions to help protect patients from harm.

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About James Titcombe

James Titcombe OBE is a patient safety campaigner and father of Joshua Titcombe, who sadly died nine days after being born at Furness General Hospital in 2008. Following Joshua's death, James campaigned for years to uncover the truth about what happened at the hospital, culminating in the 'Morecambe Bay Investigation Report' in 2015 led by Dr Bill Kirkup.

Since Joshua's loss, James' career has changed dramatically from working as a project manager in the nuclear industry to becoming one of the countries' most respected thought-leaders in patient safety – championing improvements in culture and learning throughout the healthcare environment.

Previously James was working with the Care Quality Commission as their National Advisor on Safety and recently has advised on the establishment of the new Healthcare Safety Investigation Branch (HSIB). Today he works with Datix as Patient Safety Specialist and provides his unique insight to help develop and innovate the world's leading patient safety software.

About Datix

Datix has been a global pioneer in the field of patient safety over the past three decades and today is the leading provider of software for patient safety, risk management and incident reporting for the health care sector. Datix aims to build and promote a culture of safety within healthcare organisations, recruiting professionals who are passionate about improving healthcare and championing technological innovation. Datix continually invests in its software and services maintaining a leadership position at the forefront of the worldwide patient safety movement.

Datix is focused on the health and social care sector. Its customers include public and private hospitals, primary care providers, GP surgeries, mental health and ambulance service providers. Its clients also include organisations delivering care home and domiciliary care services. Within the UK this includes more than 75% of the National Health Service. Internationally the Datix client base is growing rapidly and includes large scale deployments in Canada and the USA as well as clients in Europe, Australia and the Middle East.

Datix has offices in the London, Chicago, Washington and Toronto with partners in the Middle East, Australia and New Zealand.

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