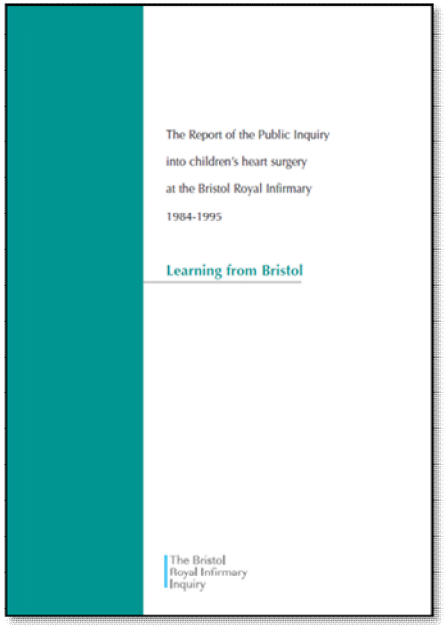
Bevan Brittan

Incident investigation: a new approach

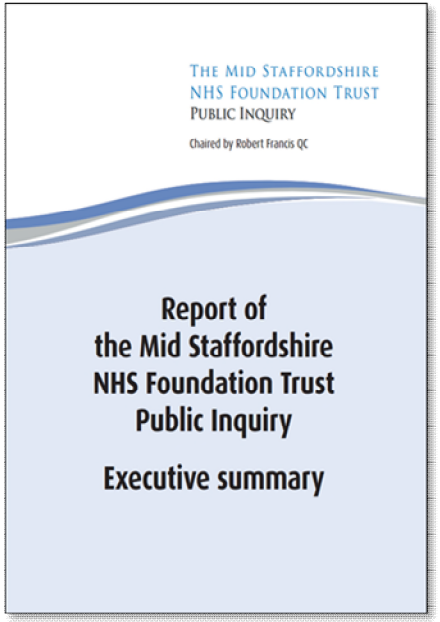
Joanna Lloyd

Features of a Patient Safety Culture

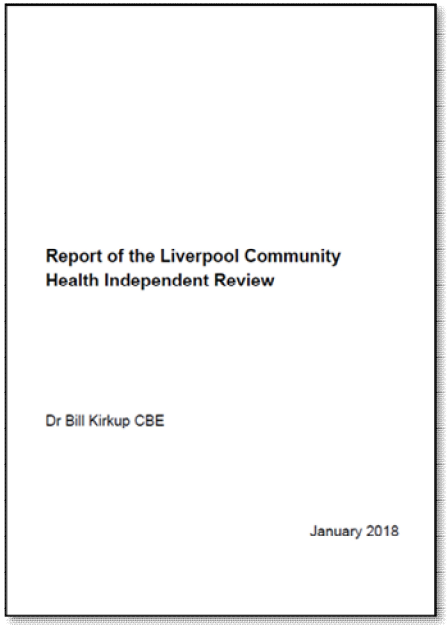
- Staff who feel psychologically safe
- Valuing and respecting diversity
- A compelling vision
- Good leadership at all levels
- A sense of teamwork
- Openness and support for learning



Bristol Royal Infirmary
2001

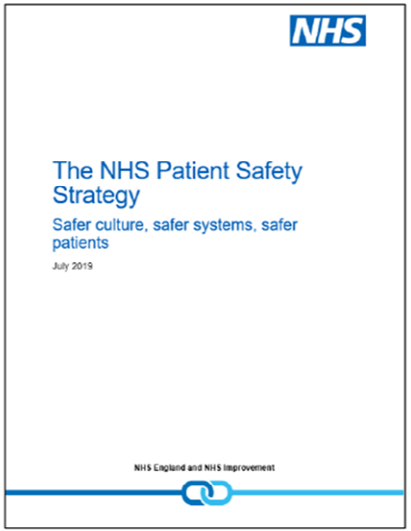


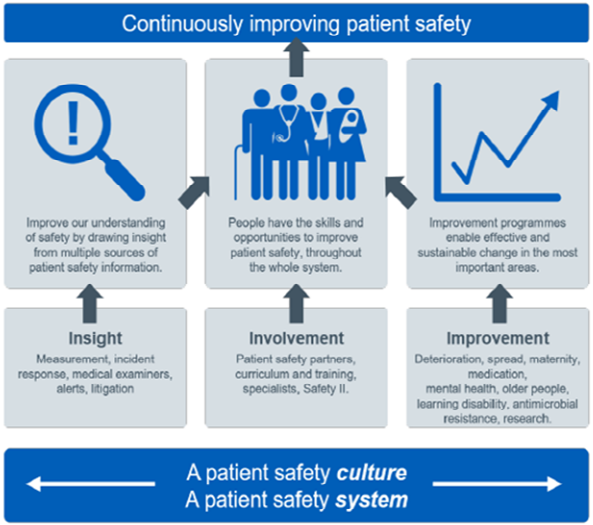
Mid Staffordshire
2013



Liverpool Community
Services
2018

The NHS Patient Safety Strategy (Launched 2 July 2019)





Safer culture, Safer systems, Safer patients

”While recognising the importance of learning from what goes well, identifying incidents, recognising the needs of those affected, undertaking meaningful analysis and responding to reduce the risk of recurrence remain essential to improving safety. Doing this well requires the right skills, systems, processes and behaviours throughout the healthcare system. The PSIRF will support the NHS to operate systems, underpinned by behaviours, decisions and actions, that assist learning and improvement, and allow organisations to examine incidents openly without fear of inappropriate sanction, support those affected and improve services”

NHS Improvement 2019

“Patient safety is about maximising the things that go right and minimising the things that go wrong…It is human to make mistakes so we, the NHS, need to continuously reduce the potential for error by learning and acting when things go wrong.”

The NHS Patient Safety Strategy July 2019

NHS Patient Safety Strategy

PS **curriculum** for training NHS staff

More effective National PS **Alerts**

National PS **Improvement Programme** delivered by PS Collaboratives

National **medical examiner** service

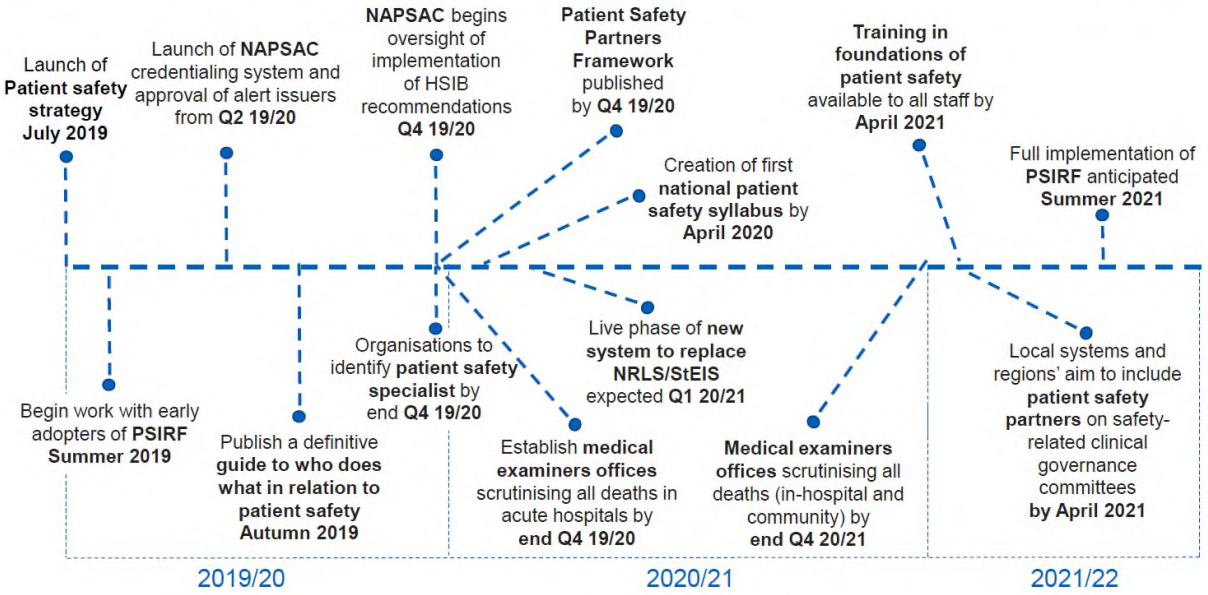
New digital incident reporting system (**PSIMS**) for staff & patients

New **PSIRF** to improve how the NHS responds to harm

PS specialists to lead safety improvement

New **cultural metrics** to measure safety

Delivery timeline for new initiatives



Slide produced by the National Patient Safety Team, NHS England and NHS Improvement

Serious Incident Framework, 2015

“The framework will ‘support continuous improvement in the way we identify, investigate and learn from serious incidents in order to prevent avoidable harm in the future”

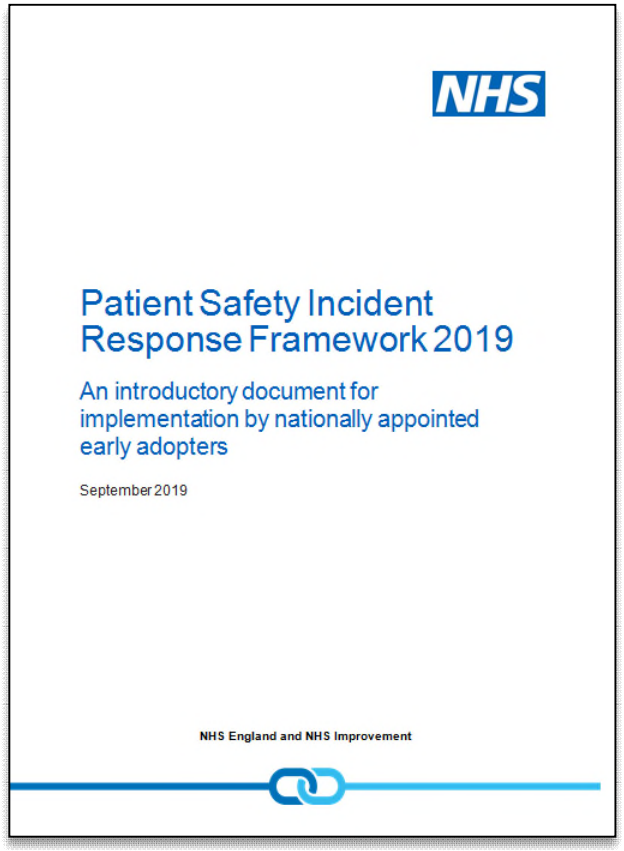
Investigation and Review Findings

There are many factors that contribute to weaknesses in the 'Serious Incident' processes

- a. Defensive cultures and lack of trust
- b. Inappropriate use of the Serious Incident process
- c. Misaligned oversight and assurances processes
- d. Lack of time and expertise
- e. Inconsistent use of Evidence-based methodology

Patient Safety Incident Response Framework, 2019

“At the heart of this work is the ambition to refocus systems, processes and behaviours to ensure responses deliver effective and sustainable reduction in risk, rather than simply applying a reactive, bureaucratic process that too often does not lead to change.”



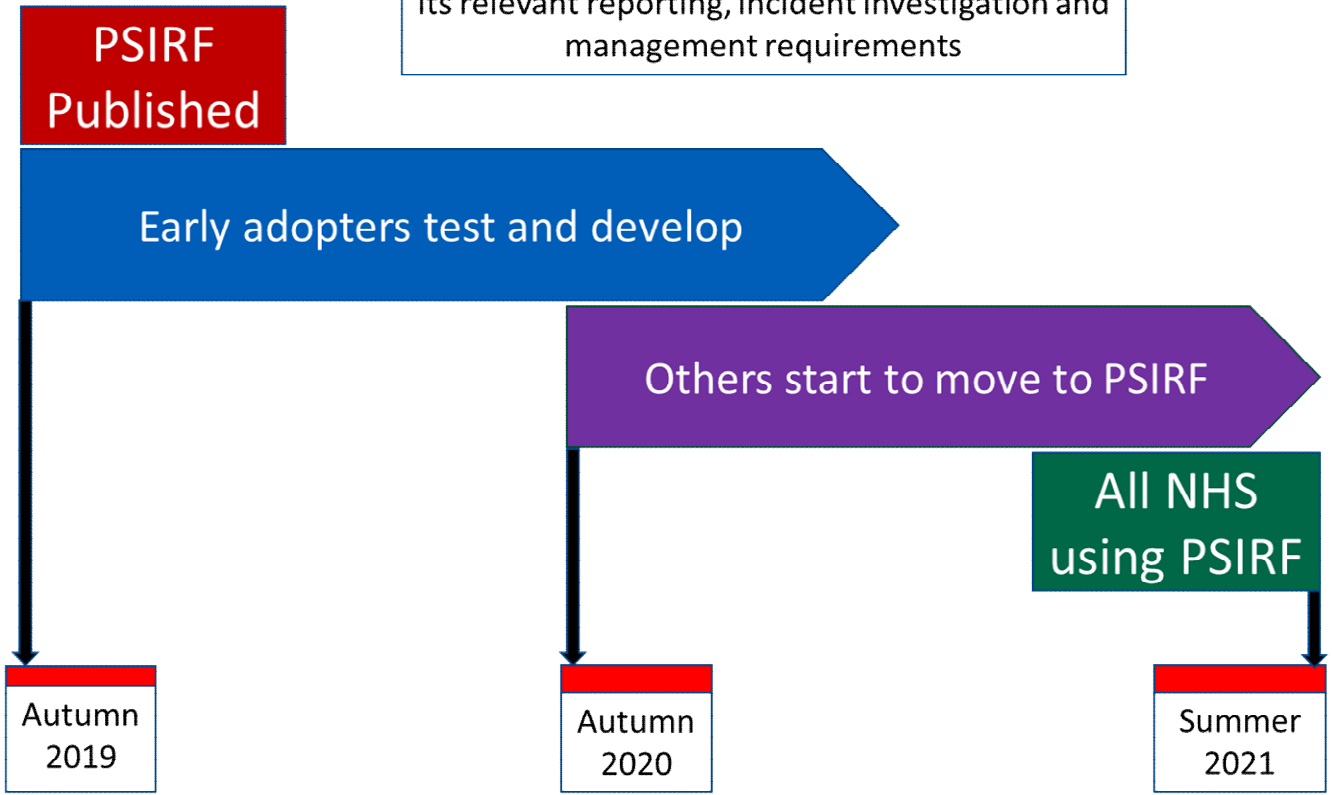
Patient Safety Incident Response Framework

For nationally appointed early adopters

(Due to be published Sept / Oct 2019)

Timeline

Until an organisation has formally moved over to PSIRF, it is expected to continue to abide by the existing Serious Incident Framework and all its relevant reporting, incident investigation and management requirements



Organisations that are not Early Adopters should be able to:

- Demonstrate knowledge of the new Framework
- Identify gaps in knowledge, skills and resource in their organisation
- Identify the likely significant challenges in implementing the new framework.

Patient Safety Incident Response Framework - Key points 1:

- Responding to patient safety incidents (not just ‘Serious Incidents’) as part of a proactive system of learning and improvement
- Support and involvement of patients, families, carers and staff affected by patient safety incidents
- National standards for Patient Safety Investigation
- A more strategic approach to the investigation of incidents to enable a greater focus on generating actions which lead to effective and sustainable improvement

Patient Safety Incident Response Framework - Key points 2:

- A new system for governance and oversight of incident management, emphasising the role of boards and executive teams, and commissioning and oversight bodies, to support the development of more effective systems for preparing for and responding to incidents
- Completion times for investigations to average 3 months and never to exceed 6 months
- Better co-ordination of investigations across multiple settings

Safety and Learning team

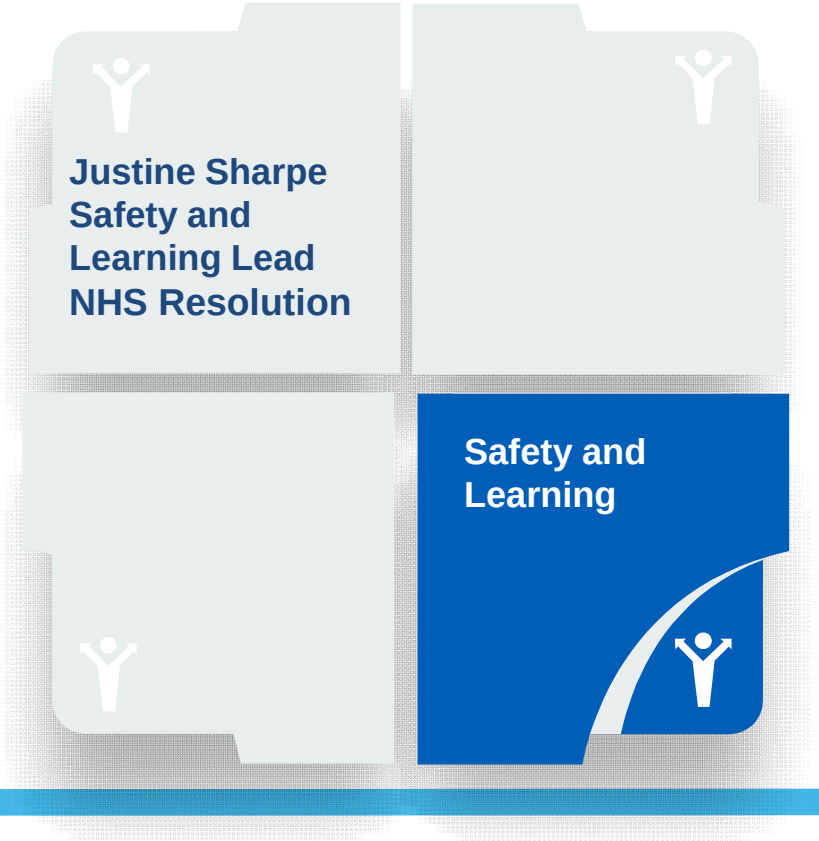
Trust Facing

Collaborative Working

Products for Learning / Faculty of Learning

Support Maternity Incentive Scheme

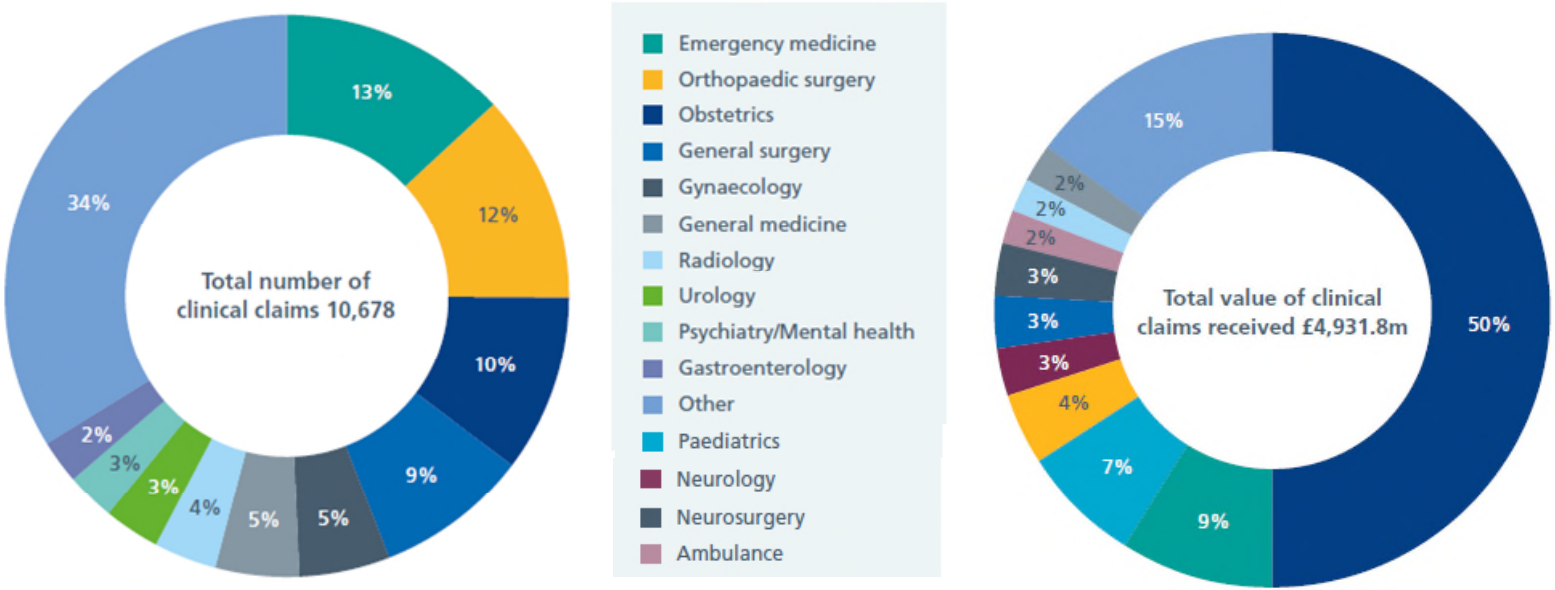
National and Regional Events



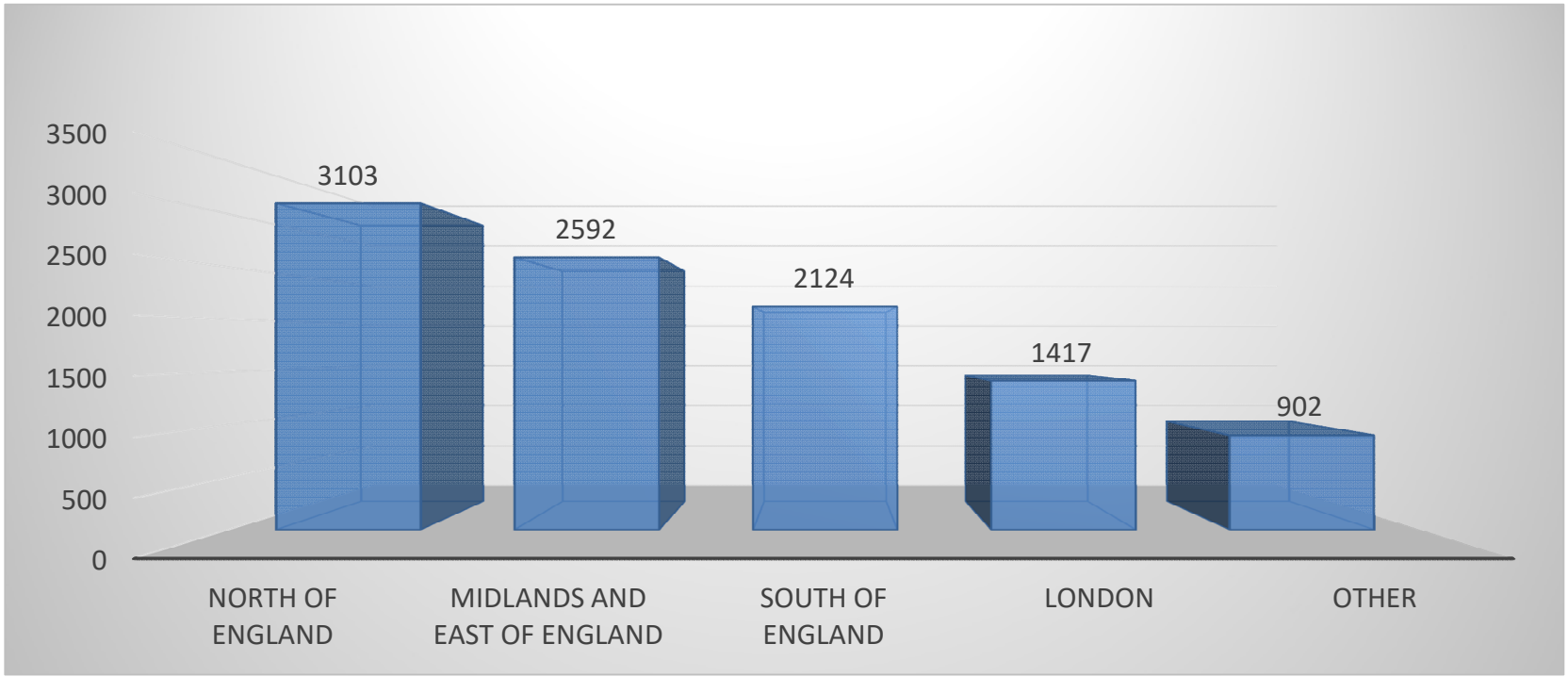
Share an improved understanding of claims risk profile to support safety activity focus

sharing learning from claims across whole health system.

Claims volume and value in 2018/19



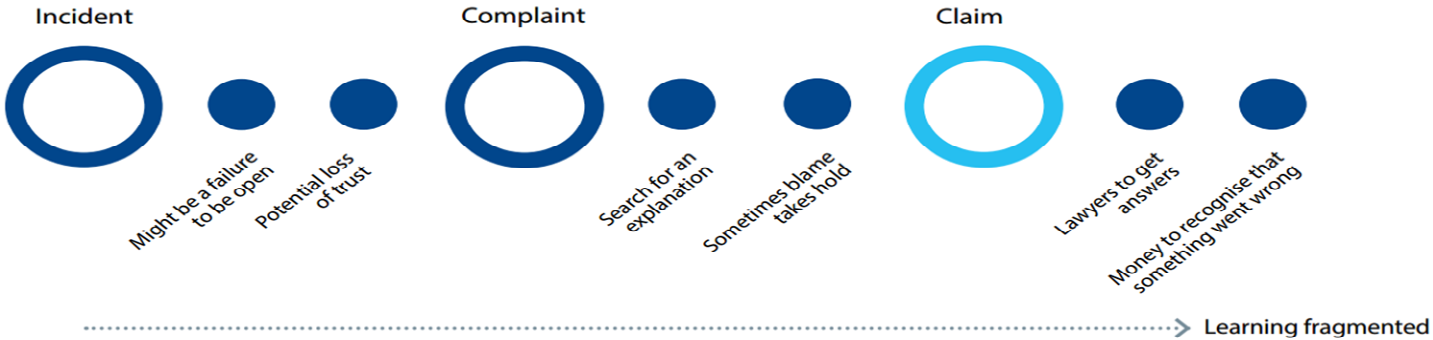
Regional Clinical Claims Data 2018/19



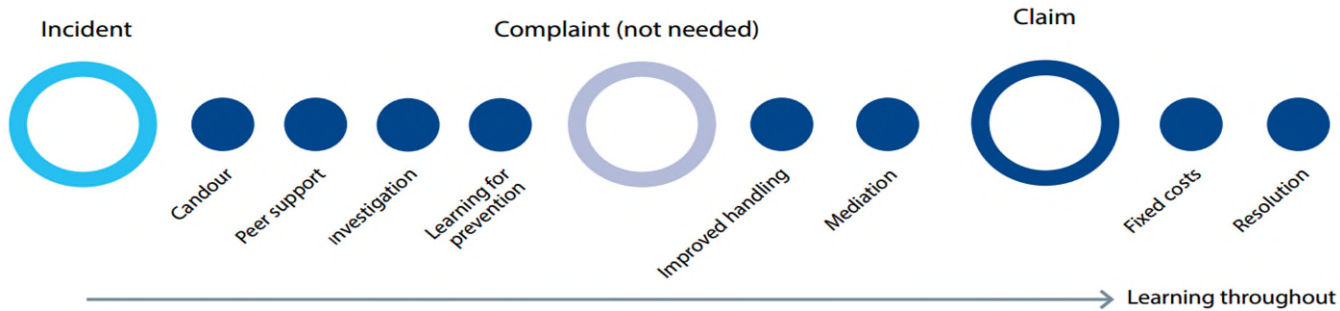
Our role – moving upstream to reduce harm

NHS Resolution

Current (worst case scenario)



Future (best case scenario)



Why do people claim?

Key conclusions

- Reactions of NHS staff …generally considered inadequate
- The majority …not satisfied with the NHS complaints' handling process
- A major external motivation to claim was suggestions from NHS staff

"I wanted to know what happened, and I wanted to know how the procedure took place. He was very ambivalent in a way, very flippant about it…I felt like I was bullied into having the procedure"

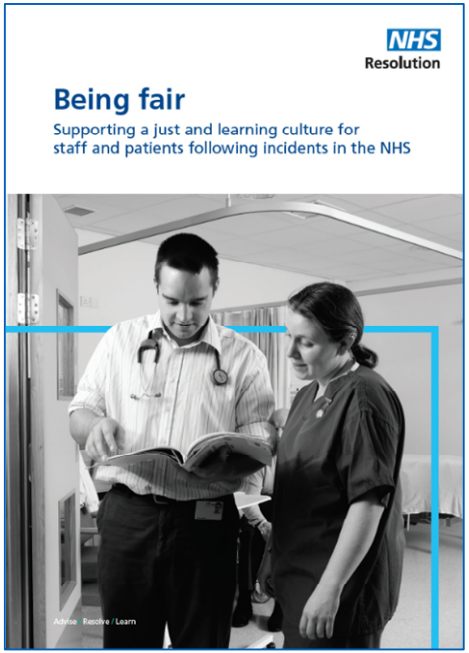
What families and staff have told us they want following harm?

- An apology / opportunity to give an apology
- To prevent it happening to someone else /share learning
- To understand what went wrong
- To have answers and be heard
- Compassion, understanding and support
- Sign posting to support where appropriate

Being fair: supporting a just and learning culture for staff and patients following incidents in the NHS

A just and learning culture is the balance of fairness, justice, learning – and taking responsibility for actions. It is not about seeking to blame the individuals involved when care in the NHS goes wrong. It is also not about an absence of responsibility and accountability.

- All actions should be understood
- Staff should be supported to learn from their actions



Chaffer, D., Kline, R. and Woodward, S.

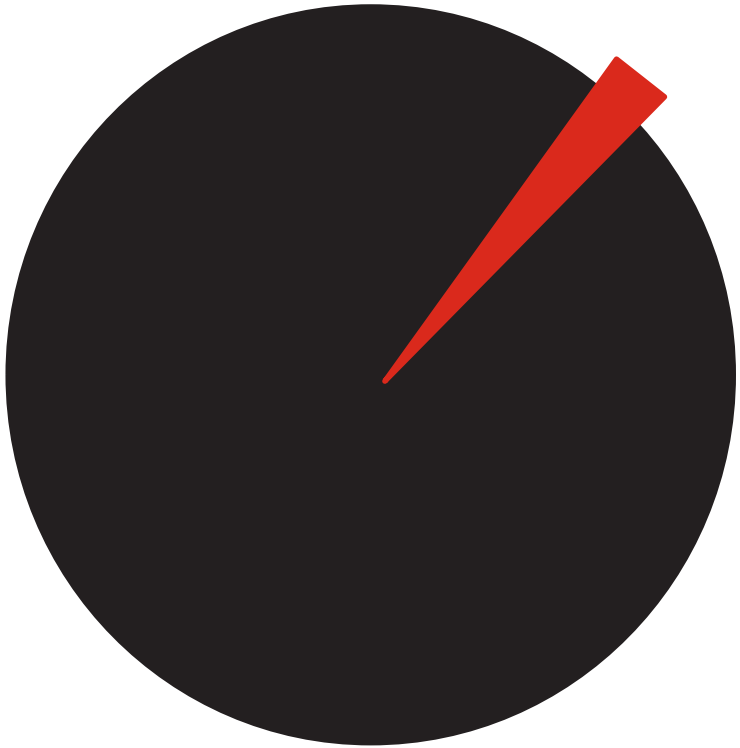
Consider recommendations that will prevent recurrence

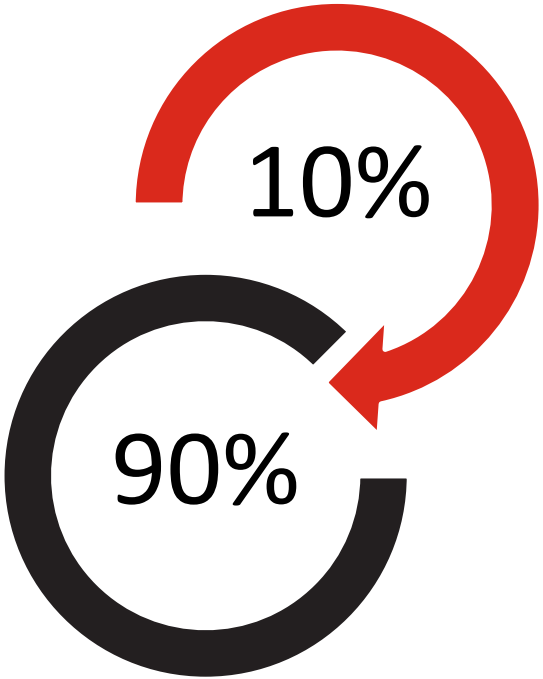
NHS Resolution

Original recommendation	An illustrative example of a recommendation with a more systemic approach
Safeguarding lead to investigate why the staff member failed to follow the policy.	Induction processes for new starters to fully cover the safeguarding policy. Annual mandatory safeguarding training for all staff to incorporate any policy updates.
That staff are reminded of the standards expected for record keeping.	Record keeping policy to be standardised across all sites in the trust. Review of all other policies with aim of standardising operating procedures across all sites.
To discuss with the emergency department doctor the need to document medication.	Psychiatric liaison services to attend medical staff induction to promote understanding of role and communication within the department.

Data from: *Learning from suicide related claims; a thematic review of NHS resolution data*, September 2018. Full report: www.resolution.nhs.uk/mentalhealthreport

Shifting focus from failure to what's meant to happen and why this didn't work?





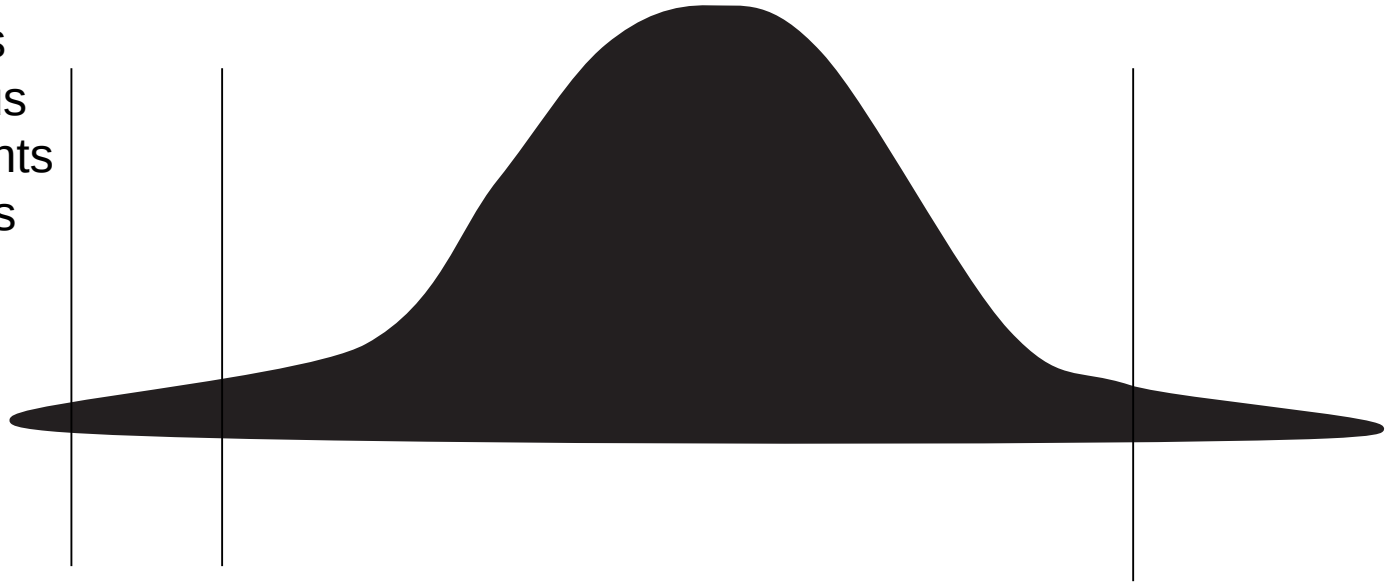
Safety I & Safety II

Rare incidents
Never events
Serious incidents
Deaths

Most incidents

Normal day to day performance

Exceptional performance



Being fair: supporting a just and learning culture for staff and patients following incidents in the NHS

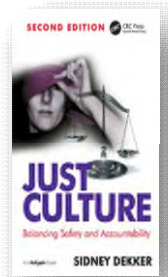
NHS Resolution

Who was hurt?

What do they need?

Whose obligation is it to meet that need?

Professor Sidney Dekker



Positive learning culture - recognition and appreciation

- When people are recognised for what they do they are 23% more effective
- When they are appreciated they are 43% more effective

Robbins M (2019) Why We Need Appreciation (Not Just Recognition) at Work via https://greatergood.berkeley.edu/video/item/why_we_need_appreciation_not_just_recognition_at_work

Conversely minor incivility can lead to..

- an immediate loss of cognitive capacity
- impacts on onlookers
- reduction in the quality and time of people's work
- potentially knock on impact on patients

CIVILITY SAVES LIVES

Dr Chris Turner
civilitysaveslives.com
@civilitysaves

In summary…

Whenever you see someone do something that you thought was lovely, stop for a minute and highlight it

Offer them the chance to gain an insight
Highlight a pattern that is already there within them
Help them recognize it, anchor it, re-create it, and refine it

That is learning

Inquest Support films https://resolution.nhs.uk/resources/films

NHS Resolution

We are delighted to share three videos to help guide staff called to give evidence at an inquest that we made with support from Her Majesty's Coroners Office, Sergent's Chambers, Clyde and Co and Guys and St Thomas's Hospital. They are not the whole picture but have been designed to have transferability to individual situations. We hope the films help dispel misconceptions about the role of the Coroner and explain how best a witness can help the Coroner and the family of the patient. More detailed support and answers to questions on inquest coming shortly.

A conversation with a Coroner

Andrew Harris, Senior Coroner Inner London South shares a brief overview on the Coroner's role and the importance of candour and transparency.

How to prepare for an Inquest

Justine Sharpe, Safety and Learning team interviews Gemma Brannigan, Assistant Coroner to uncover practical details and share tips on what to expect and how to behave as a witness in an

Giving Evidence at an Inquest

Nageena Khalique QC and Pankaj Chandak, NHS transplant surgeon provide an illustrative example of a well prepared witness giving evidence at an Inquest; covering typical questions legal

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