NHS England

DPSIMS Site Visits – Key Findings

Development of the Patient Safety Incident Management System (DPSIMS) Site Visits – Key Findings

A summary of the key messages and findings from the Site Visits

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The NHS Commissioning Board (NHS CB) was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the NHS Commissioning Board has used the name NHS England for operational purposes.

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1 Introduction

1.1 Learning from errors in healthcare

Across the NHS there is a recognised premise that reporting incidents on to a national central system helps protect patients from avoidable harm by increasing the occasions for the NHS to learn when things go wrong. This leadership function is led by NHS England Domain 5 Patient Safety, who use patient safety incident reports submitted to the National Reporting and Learning System (NRLS) to identify key themes and trends and take action at a national level to prevent similar incidents from occurring, via various routes, including Patient Safety Alerts. The alerts are a crucial part of NHS work to rapidly alert the healthcare system to risks and to provide guidance on preventing incidents that may lead to avoidable harm or death.

The existing NRLS is now 12 years old and since its development the number of reported incidents has continued to grow year-on-year; currently the database holds approaching 12 million records and continues to grow by 140,000 each month. At its inception, the NRLS was considered state-of-the-art and a world leader. However, technology advances at an exceptional rate and information systems quickly become out of date.

1.2 The DPSIMS Project

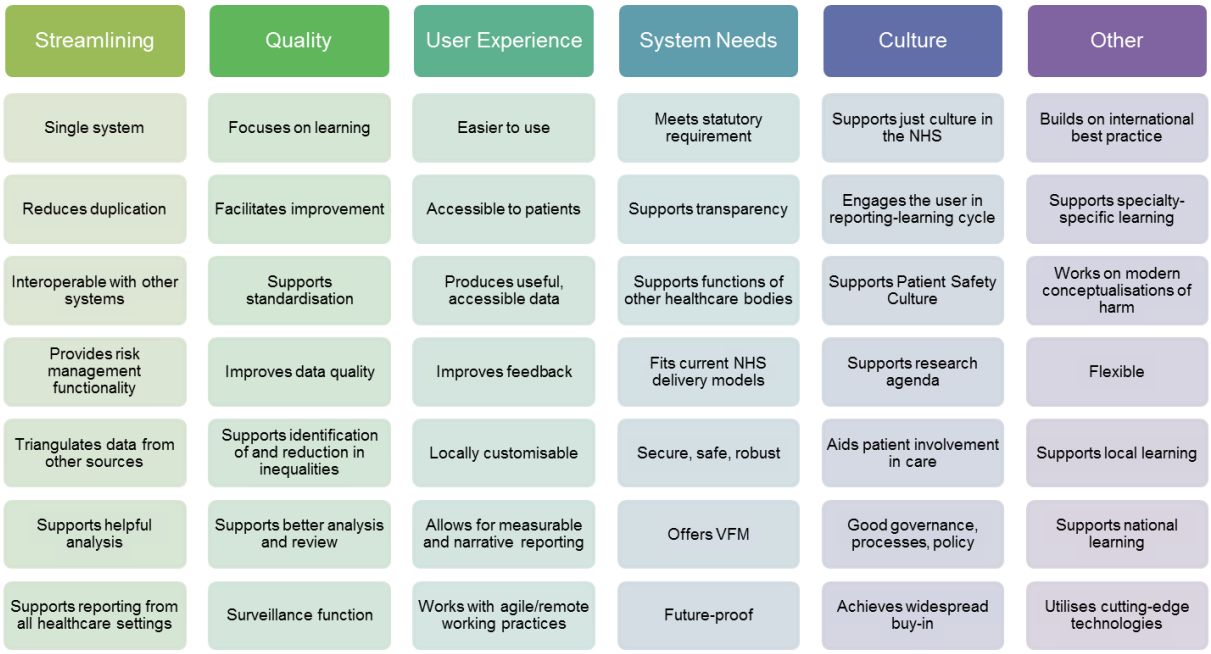
Given the age of the NRLS and the changes that have taken place across healthcare during its lifetime, it is now due for an upgrade. The Development of the Patient Safety Incident Management System (DPSIMS) project aims to identify and assess the options for a successor system that will build upon the success of NRLS, but potentially expand its functions to create a Patient Safety Incident Management System (PSIMS) that will better meet the needs of patients and clinicians within the current and future NHS delivery models. Over three years, the project will identify the most appropriate option for a successor to the NRLS, develop a business case for this option, and procure it for delivery to the NHS.

1.3 DPSIMS Site Visits

Significant work has been undertaken already as part of this project to engage stakeholders and understand their needs, and to work with technical specialists to define a long list of possible options that meet these requirements. It is with these possible options in mind that the Site Visits were undertaken, so that key elements of them could be tested with a range of provider organisations to assess their feasibility and impact from a practical perspective.

The vision is to identify a solution that meets as many of the below needs[1] as possible.

[1] Taken from http://www.england.nhs.uk/wp-content/uploads/2014/12/nrls-dev-stakeholder-update-dec14.pptx



1.3.1 Methodology

The DPSIMS site visits came out of the need to understand the impact that implementing a new updated patient safety reporting and learning system would have on provider organisations currently using the NRLS. A number of NHS organisations were invited to be a part of the DPSIMS work, resulting in ten providers agreeing dates for site visits, chosen on convenience due to restrictions on time. At each of the sites the same NHS England team attended and provided the same presentation, and asked similar questions. The responses were captured on flip chart paper and by formal note taking, and a report produced. This Key Messages document captures the common themes and findings from across the sites.

The visiting team consisted of a senior nurse with experience in incident reporting and using the NRLS, an information technology expert with experience in developing business systems requirements and an organisation expert with experience in leading culture change.

1.3.2 Sites Visited

Ten sites were visited during March and April 2015:

- Cheshire & Wirral Partnership NHS Foundation Trust (Mental Health, Community Services Provider)
- Doncaster & Bassetlaw Hospitals NHS Foundation Trust (Acute Provider)
- The Christie NHS Foundation Trust (Tertiary providers for Oncology)
- University Hospitals Birmingham NHS Foundation Trust (Acute and Tertiary Provider)
- Medway NHS Foundation Trust (Acute & Tertiary Provider)
- Yeovil District Hospital NHS Foundation Trust (Acute Provider)
- South Western Ambulance Service NHS Foundation Trust (Ambulance Service, NHS111 and GP Out of Hours provider)

- Lancashire Care NHS Foundation Trust (Mental and Community Services Provider)
- Frome Medical Practice (GP Service)
- Berkshire Healthcare NHS Foundation Trust (Mental Health & Community Services Provider)

We are extremely grateful to the hosting organisations for their time and enthusiasm in contributing to this work.

2 Findings

2.1 Common themes

Several messages emerged across all settings. These are summarised below.

2.1.1 The need for access to NRLS data

All trusts wanted more access to shared learning and stated that the NRLS is currently limited in the benefits it can provide in this area. Learning at this point in time is a local activity, with varying degrees of sharing – some only shared within their own organisation, whilst others were more active cross the local health economy, but no one was able to learn directly from national information as they simply do not have the access or ability to extract useable data from the NRLS.

The ability to draw the learning from national systems into their local systems, so it could be analysed, reviewed, benchmarked and shared in a way that met their local needs was also of paramount importance.

Whilst most trusts are regularly uploading cleansed incidents to NRLS, the most frequent dis-incentive to reporting quoted is the poor and delayed feedback from the NRLS as it appears that no users have direct access to the system. Whilst basic reports are provided, trusts are not able to interrogate data or produce their own reports

2.1.2 The NRLS is focussed on the acute sector

The current NRLS is focussed on the acute sector and this has two major repercussions; firstly the assessment of harm is only considered in a single setting, and secondly there is no ability to track incidents across the care pathway (see 2.1.10 below) to understand the root cause of the issue in some cases.

2.1.3 Clarity of incident reporting

There is a lack of clarity around exactly what “an incident” is and whether or not it was a significant event that needed reporting. Although there is guidance available, the feedback was that this was not well understood and potentially allowed for interpretation that then could skew the assessment of any patient safety incident.

2.1.4 The need for standard definitions of terms

Standardisation of national categories of incident to ensure comparisons can be made between different organisations would be useful. As individual organisations have set up their systems based on local requirements, there is a lack of opportunity to effectively compare across similar organisations.

A number of groups fed back that it would be beneficial to have a nationally agreed Minimum Data Set.

2.1.5 Utilise data intelligence tools to provide better reports and data packages

It would be beneficial to ensure that dynamic dashboards can be customised for individuals in near real-time, also supporting 'drill-down' capabilities that replace cumbersome monthly reports.

Business Intelligence tools should be exploited, allowing trends and themes to be identified and visualised, which can be triggered when threshold values are met.

2.1.6 The need for an intuitive, flexible system

The ability to input data in to their own local systems and then simply upload to national learning and reporting systems by the "press of a button" was a need echoed by everyone.

The local IT systems currently available reflect more advanced features than NRLS: e-forms, near real-time reports and dashboards, which allow greater alignment of the systems to support local processes and their learning culture. The local systems and tools in place reflect that the current NRLS has not kept up with local requirements.

E-forms should be extended and expanded with more rules to minimise the need for human data cleansing and validation, before the data is uploaded for use elsewhere. Forms must be made more intuitive and easy to complete with helpful instructions for less IT literate staff.

2.1.7 The single point of capture

Due to the culture of conflict between clinical and administrative activities, clinical staff require instant access to incident reporting systems to ensure that they are not required to return to a base to complete reports.

All trusts wanted to use a single point of capture – to be able to enter data once and then share it with all the systems that need to use it. In particular, there was a call for the NRLS and STEIS to be integrated. A successor system that managed both of these objectives would be welcomed.

A key need was the 'One Front Door' into a system that is able to automatically export data sets electronically to other systems, once they had been validated. This will reduce considerably the amount of manual effort currently required of trusts.

However, as stated above, local customisation must be preserved, and the different requirements of different types of agency and stakeholders must be recognised.

Easy access to the system from anywhere at any time by authenticated users with managed roles and permissions is key.

2.1.8 The need for integration with local systems

The biggest fears about this project were less about the fear of change, and more around of the loss of local information systems. One Trust summed it up very clearly – *the system needs to either integrate with local systems or completely replace the functionality*.

2.1.9 Patient reporting

In determining who should be able to report safety incidents, the question of patients reporting was raised and generated a lot of debate, with those in favour and those opposed. Concerns raised during the discussion were about the need to clarify the difference between complaints, incidents, praise and compliments that patients may wish to report[2].

2.1.10 The ability to regard each incident as a case in order to monitor workflow

Clinicians from the Ambulance Service reported issues with allocating and tracking incidents; because there are involved in a small part of the patient journey they noted the difficulty of learning from outcomes as multiple agencies were involved in reporting and it was difficult for them to get feedback.

Incidents have a lifecycle and a set of outcomes that need to be shared with all people involved in managing the 'case', since the learning will only be obtained if outcomes can be shared. Currently systems do not make it easy to 'close the loop' in terms of action outcomes and longer-term learning. Future systems must therefore have the ability to allow multiple users from different organisations to collaborate together on a 'case' and share the outcomes.

The system must be much more pro-active than reactive and be able to alert people when feedback or other actions are required within the 'case'.

Using the NHS Number could be considered as a unique identifier to support workflow, provided provision is made to remain compliant with the Data Protection Act regarding Personal Identifiable Data.

[2] It is worth noting that patients' themselves raised this concern in the Patient Workshop. They too asked for "single front door" for providing feedback that would intelligently identify if the content was a complaint, compliment, safety incident, etc. and automatically treat the report accordingly. See here for details: http://www.england.nhs.uk/wp-content/uploads/2014/10/nrls-dev-prof-wrkshps-rep.pdf

2.2 Recommendations

In additional to addressing the issues raised above, the visiting team has made the following recommendations.

- That a “do nothing” or “do minimum” approach not be taken – continued reliance on existing systems bears too much risk, and does not adequately support providers to achieve maximum learning from Patient Safety Incidents
- That plans for the future system take into account the costs that will be borne locally in aligning systems, supporting migration, and providing training

2.3 Conclusion and next steps

The messages received during this process aligned well with issues identified in previous stakeholder engagement, and so the Site Visit process has served to both validate the engagement to date, and to provide additional detail on these issues from a provider perspective.

This summary will be made available transparently on the website. It will help inform decisions taken to shortlist options from the initial longlist, and continue to inform the definition of detail of the new system as the project progresses.

A further update will be published once the shortlisting process is complete.