



NRLS Development Project: Report of the Listening Events for professionals

National Reporting and Learning System (NRLS) Development Project

Report of the Listening Events for professionals

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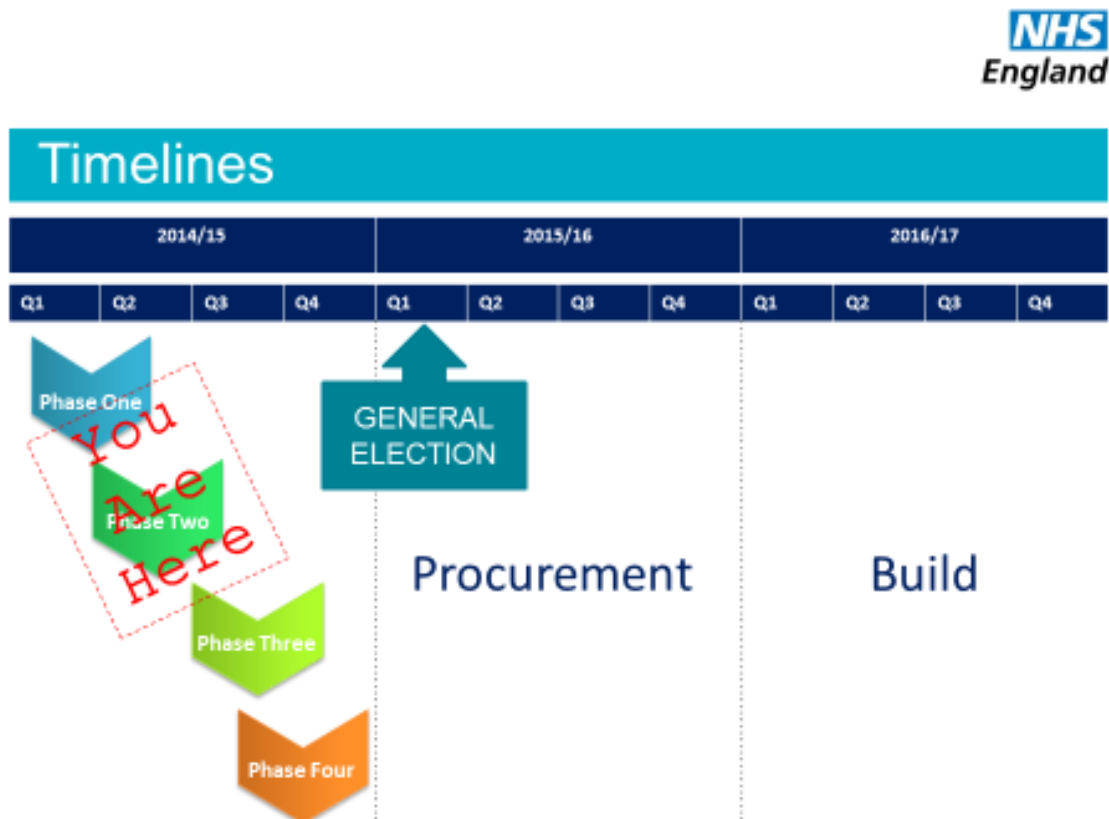
1 Purpose and Context of this Document

This document presents the outcomes of the two listening events designed by the National Reporting and Learning System (NRLS) Development Project for professional users of the current NRLS.

The NRLS Development Project is a three year project to specify and procure replacement software to support the NHS's ability to learn and improve on the basis of reported experience. The Project is currently working towards a Business Case for this procurement. Key elements of the Business Case include:

- Strategic context within which the replacement software will be deployed
- Required benefits of the software following deployment
- IT capability to support those benefits
- Potential risks to the realisation of the benefits

The graphic below shows the timeline for the project. Phase Four refers to the completion of the Business Case, while Phases One to Three include engagement with the user community.



As can be seen from the graphic, this listening event was timed early in the project in order to give the user community maximum opportunity to impact the scope and approach that will be taken.

Engagement in Phases 1 and 2 has included:

- A survey publicised through user networks via email, which gathered over 600 responses
- A Focus Group tasked with reviewing draft project objectives against the outcomes of the survey
- Three listening events -
 - a workshop for patient advocates
 - two parallel workshops for professional users of NRLS of which this report is the output¹

2 Workshop Process

The aim of the Project in convening the workshops for professional users was to “inform the development of requirements for the successor NRLS by understanding the ambitions, concerns and tensions felt by the current user community.”

The design of the workshop interpreted this in terms of three typical responses, each of them valid, which are often encountered when a change to working practices is proposed:

- Some responses highlight the *benefits* of change, in terms of improved performance and capability and of the fixing of problems, issues and inefficiencies that affect the current arrangements and working practices
- Some responses focus on the *practical implications* of the change: what will be required for a successful transition to new working practices and the avoidance of chaos or unintended negative consequences
- Some responses focus on the *risk* of change: the possibility that the change may not have the desired impact as a result either of the project not delivering or of challenges within the receptive environment (in this case the NHS as a whole)

These three responses align to three key aspects of the business case (benefits, management case, and risk) and are equally necessary if a rounded picture of the proposed change is to be achieved. As a shorthand, these three types of response are characterised respectively as Dreamer, Implementer, and Sceptic, and the delegates were asked to consider the NRLS successor system from each of these perspectives.

In order to ensure that benefits and risks were examined in a holistic way, delegates were asked to consider both the proposed software system and the wider set of

¹ The output of the patient advocate event is attached as an appendix to the current document

working practices through which the NHS learns in a structured way from patient outcomes and experience, and which constitute the real-world reporting and learning system.

Similarly, the understanding of the “user community” was deliberately broad. Users were considered to be not just those whose roles involve day to day interaction with NRLS software (whether inputting incidents or querying the database for learning) but those whose strategic aims will be furthered by the learning and reporting that the software enables.

For the purposes of the discussion, this broadly-defined user community was segmented into smaller, but still large, groups. Delegates were asked to identify these and generated the following segments or groups of users (alternative names were applied to broadly similar categories at each workshop).

Segment	Description
Patients and carers	A person directly experiencing patient care or caring for someone who is – an owner of individual incidents and experience as reported on the system.
Clinicians	A person directly offering patient care – an owner of individual incidents and experience as reported on the system.
Operations/performance management	A person involved in creating the context within which patient care takes place. This group includes commissioners, the management and leadership of providers such as Trusts and GP practices, and performance managers and those involved in clinical governance.
System developers/Strategic users	A person whose role addresses the evolution, development or regulation of the NHS system. This group includes regulators, suppliers of services, ministers etc.
Customers	A person whose interests align to the outcomes of healthcare in general. This group includes taxpayers and patient advocacy groups.

The following sections set out the consolidated analysis that emerged from discussion at the two workshops.

3 Dreamer

The “dreamer” perspective aligns to the vision for the NRLS development, and the benefits that might be achieved through changed working practices supported by an improved IT infrastructure.

3.1 Patient perspective

Delegates at this pair of workshops had been able to take on board the output from the patient advocates' workshop held the previous week, so their sense of the patient perspective was informed by that work. This summary is thus best read as a professional reframing of where the patient interest lies.

Delegates articulated the vision for patients in terms of empowerment and communication. Patients will have a high level of confidence, both in their ability to access the system to report their experience, and in the impact of that experience on professional behaviour and on outcomes. As a result they feel safer.

The system enables very good communication. Patients are able to describe their experience authentically, using a single process (a "one stop shop") to describe experience of any type. In return, they have a clear understanding of the process of reporting and learning and are able to track how their experience is being managed. They are treated as partners in a learning process and are able to understand their own experience in a wider context. For example, they know whether their experience is unique or common in the NHS.

3.2 Clinician perspective

The vision for clinicians focuses as much on culture as on software. In the vision, reporting is as natural as making clinical notes, and as simple. Conversations about safety become the norm, and even difficult topics, such as poorly performing colleagues, are tackled. Clinicians are confident that they are "safe" to report and that there will be no untoward consequences, and that they will be rewarded for doing so and involved in the learning that ensues. The system is geared entirely around learning, without a secondary performance management function.

Clinicians will be able to access patient safety information at many levels of detail, from high level reports on safety "themes" to drill-down information about specific pathways and specific incidents. It is possible to gain a holistic picture: the patient's voice is as clearly heard as the clinician's.

3.3 Performance management perspective

Despite the apparent concerns expressed from a clinical perspective, many delegates were convinced that there is a role for the NRLS in performance management. However, they thought of it in connection with outcomes and performance at system level rather than as a tool for managing individuals, and so the vision was similar to the clinical one. Above all, the NRLS provides assurance that the NHS, and its organisational components, are capable of learning and improvement. As a result, public confidence in the NHS rises. It is possible to identify learning themes and to design and implement change more quickly. There is an open and transparent culture.

The successor NRLS process absorbs and replaces processes that are currently supported by separate systems: STEIS, CQC, and other regulatory systems, and has a very flexible "front end" user interface.

3.4 System perspective

From the perspective of system users, such as regulators, delegates emphasised a requirement to develop greater confidence in the underpinning accuracy of data and information used to form judgements about effectiveness. Like clinical users, such “system” users are interested in benchmarking and calibrating information so as to identify trends, weaknesses and strengths across the NHS system and in specific parts of it.

The requirement is for data to be internally consistent and of high quality. It follows that data entry is governed by a set of standards which are reliably adhered to. System users are primarily users of the output of the NRLS, so their interest is in the improved functionality for interrogation and analysis.

3.5 Customer perspective

This perspective grouped together the interests of users who represent patients and carers and the public, but from a strategic perspective rather than as hands-on users of healthcare services.

The vision for this group is of a service that is continually and demonstrably improving. The NRLS’s role is to give these users a voice and a channel for feeding back experience and for monitoring progress across the board.

4 Implementer

The implementer perspective highlights:

- Prerequisites for a successful deployment
- Conditions for transition to new working methods
- Changes to the “receptive environment:” the culture and behaviours that will be required to realise benefits from the successor NRLS software system

4.1 Messaging

Delegates’ discussion of the new NRLS repeatedly highlighted the view that the narrative surrounding the deployment of the system is as important as the design of the working practices and the software. The NRLS needs to be better aligned with other policies and strategies, both in patient safety and in the wider NHS, and the links with provider, commissioner and regulator development made more explicit. Once this strategic alignment has been achieved, it will be necessary to explain it through clear and consistent messaging. Delegates were very clear that this work cannot wait until the software is closer to completion; it needs to begin immediately in order to have the best chance of creating a hospitable environment for the eventual deployment of the software. In the short term, this messaging will also support the development and deployment of interim improvements to the current NRLS system.

Strategic messages suggested by delegates included:

- NRLS articulates a vision for patient safety as a shared enterprise, owned equally by patients, clinicians and system managers and leaders
- It's not just about the IT – it's about a culture of openness and learning
- It's a good thing to report, and well-run organisations will expect and reward reporting
- Commissioners should be clear about the safety and outcomes rationale for reporting

Delegates also supported a programme of more tactical messaging, including:

- Well-edited stories of good practice in reporting and learning
- The construction of a strategically-aligned “communication toolkit” designed to be branded and used at local level
- Evidence of the value of the current NRLS and its outputs
- Expectations and plans for the future development of the NRLS including both incremental improvements and the successor system

4.2 Reporting

Barriers to reporting should be removed, and explicit incentives put in place:

- Reporting process should be simplified as far as possible
- Reassurance should be given that information will not be used punitively, via the consistent use of the incident decision tree
- Explicit incentives for clinical reporters should be developed, including peer recognition and professional progress
- Learning from experience and consequent behaviour change should be tracked and demonstrated
- Some staff groups such as pharmacists may need to have specific concerns addressed
- There need to be better protocols for updating and reviewing incident reports as more information becomes available
- There need to be better processes for capturing and using feedback, including positive experience, and relaying it in a timely and consistent way to frontline staff – this would include reframing “near misses” as “actions that saved the day”
- Reporting levels themselves need to be benchmarked and normal and expected ranges identified

4.3 Learning

There needs to be investment in the sustainable improvement of the reporting and learning system, retaining a focus at all times on its outcomes. Productive approaches would be:

- Benchmarking of reporting and learning
- Finding ways to monetise (derive income from) the information in the system, for example by linking to research organisations
- Working the data harder in order to generate added value, both in detailed analysis and in the identification of trends
- Building in a feedback system based on specific early warning metrics and indicators
- Developing qualitative as well as quantitative approaches to analysis

The aim of this work would be to create a virtuous circle in which increasingly trustworthy data is generating increasingly useful information.

Nevertheless, it is important to “start small” and build up on the basis of experience, using feedback to develop and refine the approach.

4.4 Integration

Delegates highlighted a number of processes in the current system which carry risks for the development of reporting and learning:

- STEIS is an example of purely negative reporting, and runs counter to NRLS principles
- Commissioners often ask for per-incident reporting which duplicates the providers’ incident management processes

By contrast, there needs to be a standardised methodology for incident management, standardised through training and supported by a national definition of avoidable harm. This methodology will be:

- Aligned with the Review of the Serious Incident Framework at NHS England
- Taught through clinical curricula monitored by HEE
- Aligned with MHRA reporting

Since this methodology will be supported by IT, there is a need for a standardised set of *entity names* and *relationships* that form an end-to-end conceptual model of the incident reporting process. This conceptual model can then be implemented through the logical model that underpins the design of the successor NRLS².

² In an IT system, there is a need for a standard way of describing incidents and the reporting process, using precisely-defined terms (“entity names” in database terminology) and a structured way of managing them in software (“relationships”) so that reporting can be precise and the information in the system can remain reliable and useful when it is analysed.

4.5 IT system design

Over the course of the workshops, delegates gradually articulated their hopes for the successor NRLS software in the following terms:

- There will be a number of different interfaces making use of different technologies, including mobile applications but also leaving room for patient reporting to be enabled by professional support
- There should be a “patient facing” set of interfaces on various platforms
- These interfaces will take account of the variety of settings and the nature of reporting that is likely in each setting
- There needs to be capability supporting contested interpretations of the same incident, reflecting that one incident may have several owners each with a equal right to describe it
- Incident reports need to be able to evolve over time as more information becomes available, using a structured incident lifecycle
- Work underway at the NRLS Research and Development Programme at the Centre for Health Policy, Imperial College London, suggests it may be possible to extract structured data from free text incident reports
- The system should be able to pull standard data from other systems, avoiding the need for double entry
- There should be a link to the NHSIQ hub

5 Sceptic

The sceptical perspective aligns to the risks of the project. It starts from the question “Why won’t this work?” as an investigative strategy to anticipate issues that may arise during implementation, or that may impact the achievement of benefits. It may also highlight tensions or dissonance in the strategic objectives of the project.

Delegates were asked to use this strategy from point of view of the same segments of the user community that they had worked with before, in order to have an opportunity to identify risks right across the spectrum of activity that will be supported by the successor NRLS.

Understandably, some of the issues and risks highlighted were simply the inverse of the vision that they had previously articulated. For example, having expressed the ambition that the system would be simple to use, the sceptical perspective highlighted the concern that it might in fact be complicated. Although this was a valid process, for the sake of brevity, these “inverse visions” are not captured here.

For similar reasons, risks arising directly within the NRLS Development project are not listed here. These are the familiar risks to cost, time and quality that can affect any project: the system might not work, might be late, might cost too much. What is summarised here are the risks to the realisation of the visions set out in the Dreamer section above.

5.1 Scope

Delegates were concerned that the very ambition of the project creates its own risks. Incident reporting that is deeply embedded in routine clinical activity of necessity touches many processes. This appears to imply that NRLS needs an interface with many other systems (though this might in practice be mitigated by leaving that work to local risk management systems). Developing a system with such a broad scope is not only a technical but a political challenge, delegates felt.

There was also a concern that, despite good intentions, the system might have an inbuilt bias towards the acute sector, with insufficient reach over the whole health economy. Similarly, the sceptical turn raised the worry that one of the user groups, for example performance managers, would have their needs fully met at the expense of others. A variation of this is that the system might be designed around the needs and vocabulary of clinicians rather than patients.

5.2 Capability

In sceptical mode, delegates worried about the capability of the NHS to report reliably and consistently, using standardised terminology, with a consequent worry that the data in the system might not be high quality or might struggle to establish its usefulness. Such skills are not currently part of clinical curricula.

5.3 Strategic tensions

Delegates pointed to the real tensions that exist in the public and policy narrative around patient safety reporting. They are concerned that incidents that are one day a “no blame event” and an opportunity for learning may the next day be seen as systematic failure. At a larger scale, the duty of candour is putting the NHS under pressure to be more open about things that go wrong. It was not clear to delegates that this agenda is compatible with open and blame-free reporting. In practice, the outcomes would be determined by interpretation and by divergent and possibly conflicting accounts of the same information. And there was a persistent worry that public opinion, in the shape of the media, is yet to grasp the value of incident reporting, and is not responsible enough to use low-harm data without demanding sanctions.

In such an environment, practices and Trust boards might find it difficult to be whole hearted in their encouragement of routine reporting, because of the risk of reputational damage.

5.4 Technical culture

Currently, the NRLS receives most of its reports from local risk management systems. There is substantial investment in these and a workforce has built around

them. Delegates were concerned about the resistance to change that might be encountered in asking this workforce to change working practices and systems.

6 Conclusions

Having considered the NRLS successor from the sceptical perspective, delegates were invited to revisit both the ambitions (“dreams”) and the implementation approach.

Having considered the strategic tensions just described, delegates felt it was important to refine the vision for transparency and openness. Openness should be made the main goal, with the explicit aim of supporting clinicians, even at the expense of other agendas. This might partly translate into an explicit system focus on surveillance.

Delegates also felt that a stronger case needs to be made for the reporting and learning system. The successor system needs to be able to spot grossly abnormal patterns of outcomes, such as those seen in the list of Dr Harold Shipman.

It also needs to adjust to new patterns of risk. With an older population, more people are vulnerable to safety risks that arise from the combination of many interventions, and from the complexity of pathways, rather than from individual incidents. As one delegate commented: “Risks in the community are cumulative”.

As far as implementation was concerned, delegates recommended that the following activities be undertaken in parallel with the NRLS Development Project and the business case and procurement it will be carrying out. This work will increase the receptiveness of the environment when the software is available. Most of these activities may be described as liaison and alignment with other activity, rather than as additional work to be directly carried out by the project.

Much of this liaison will be carried out by Domain 5 of NHS England, working as necessary with other teams within NHS England and with other system leaders.

Activity	Suggested owner/partner
Align with the Review of the Serious Incident Framework	Domain 5
Align the reporting model with the clinical curricula on patient safety	HEE
Develop a national agreement about what counts as avoidable harm and how it is to be mitigated	Domain 5
Give clear consistent messages about NRLS development	NRLS Development/Domain 5
Target employer behaviour	NHS Confederation/Domain 5
Work with patient advocates to further understand how patients want to report	NRLS Development
Align with MHRA reporting	MHRA

Develop free text analysis	NRLS Research and Development Programme at the Centre for Health Policy, Imperial College London
Separate benchmarking from learning process	Domain 5

7 Next Steps

At the end of the workshop, Lucie Mussett, the project manager, promised to keep in touch with those who had signalled continued interest, and to offer an opportunity for further engagement, including the chance to comment on the emerging options in the coming months.

Appendix 1: Report of the Patient Engagement Workshop, London, 15th July 2014

National Learning and
Reporting System
Patient Engagement
Workshop 15th July 2014



National Learning and Reporting System

*Report of the Patient Engagement Workshop,
London, 15th July 2014*

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1 About the NRLS Development Project

The NRLS is a database of patient safety incident reports submitted by organisations across the NHS, and directly by patients, specifically for purposes of learning. Hospitals regularly upload incident reports from their local systems to the NRLS, where they are analysed by national patient safety experts to spot trends, specific incidents of concern, or emerging risks to patient safety. This triggers action to help address the identified issues/risks through the provision of advice and guidance, especially through Patient Safety Alerts, which are clearly-written descriptions of a risk and what to do about it.

The NRLS Development Project will, over 3 years, create the successor to the current system, which was designed in 2001 and went live in 2003. Its design, and the way it is used, reflects the shape and working practices of the NHS a decade ago. Since then, much has changed:

- More and more of the NHS's work is being carried out away from hospitals
- There have been significant developments in "safety science" – the techniques of learning from experience in order to reduce risk
- The public expects the NHS to be far more open about its performance, including when things go wrong
- The work of the NHS is regulated in a completely different way, following the creation of CQC and its inspection regime
- The work of the NHS is managed in a different way as a result of the 2012 Health Act of Parliament

The new NRLS must therefore be much more than simply a technical upgrade of old software. It needs to support a completely new way of working that is in line both with the new shape of the NHS and with current best practice.

2 About this document

This document records the outcomes of a workshop for patient advocates held on 15th July 2014. The workshop was designed to help the NRLS Development Project to understand:

- How patient experience might best be captured and used in the new NRLS
- The "patient perspective" on some of the most challenging strategic choices facing the project

At the workshop, delegates were asked to consider some fictional stories which illustrate some of the tensions which arise when patients feed their experience back to the NHS. These stories may be found in the following section, together with some of the analysis that emerged at the workshop.

3 Challenges for the new NRLS

Accountability/Improvement: Margaret's story

Margaret's father Roger died recently of complications arising from Parkinson's disease. In the last months of his life, Roger was fed through a PEG tube into his stomach as he was no longer able to swallow safely. Following a short stay in hospital, Roger spent some time in a specialist reablement ward in a community hospital. The hospital was short of PEG-trained staff and Roger often had to wait a long time for his meals. Sometimes inexperienced staff unsuccessfully attempted to feed him, resulting in distressing episodes. Roger's mood deteriorated and he started to become confused. Finally, Roger collapsed and was rushed to the emergency department, but he died a few days later.

Margaret is left with mixed feelings. She does not believe that the care he received at the community hospital directly caused her father's death, though she does wonder if it hastened it. She wants the community hospital to change its training and staff profile so that there are more PEG-trained staff available. She wants the ward manager to be held accountable for the poor experience and care her father received, and to understand the impact she believes it had. At the same time, she wants to report the incident accurately and helpfully so that similar units can learn the lessons about the need for PEG-trained staff. She thinks that it is human nature to be defensive, particularly if someone has died, and that this might get in the way of the learning. How does she share her story in a way that will be helpful to the NHS and other patients, and will also ensure that something changes at the community hospital?

This story reflects the tension that can arise between the need to fix local issues and the desire to learn wider lessons. Modern safety science argues against a "blame culture" where somebody is at fault whenever there is a bad outcome. Safety improves, runs the argument, where people are able to report negative experience without fear of reprisal or criticism. On the other hand, where people have suffered avoidable harm, it is natural to want to hold people to account and to receive an apology. Currently, the complaints process is used to ensure that people receive recognition for unwarranted harm or distress, while incident reporting is a separate process used to manage risk and capture learning. Can these two processes be brought together? If not, how do we make sure the correct process is chosen?

Authentic vs Measurable: Hazel, Maruska and Belinda's stories

Hazel recently gave birth in the obstetric unit of her local hospital, where she was attended by a community midwife. Hazel had planned to give birth at home but a small bleed early in labour had meant that the midwife had insisted that she go to hospital for safety reasons. After this hiccup, labour appeared to be proceeding normally. Several times during labour

the midwife left the labour room, returning each time after a few minutes looking upset.

When Hazel's labour progressed to second stage, her midwife rang the bell to call for assistance. However, no one came. The midwife repeatedly rang the bell, but no second midwife appeared. Eventually, her baby was born with the single midwife managing as best she could, clipping the umbilical cord and ringing the bell one final time as she prepared for post-natal checks. At this point, a midwife rushed rapidly into the labour room, sized up the situation, and proceeded to cut the baby's umbilical cord on the wrong side of the clip. The cord stump began to bleed profusely, and it was several minutes before the two midwives had managed to reclip the cord stump and stem the bleeding.

Later, Hazel reflected on the experience. Clearly, there had been a mistake by the second midwife, and there should have been more staff in the room at the time of the birth. However, Hazel believed that the main issue was that there appeared to be a very poor relationship between her community midwife and the staff who were based at the hospital.

Hazel decided to file a report on a patient incident reporting system. She was able to document the mistake over the clip and to record that there had only been one midwife with her. However, she felt that these were just symptoms of the deeper problem. She did not feel that the form had helped her to record her incident properly.

Afterwards, Hazel's report was analysed along with many others by Belinda, a patient safety analyst at the hospital Trust. There were no incidents similar to the mistake with the cord, and very few incidents of there being too few midwives at the point of delivery. Hazel's experience was not brought to the attention of the Trust management.

Maruska gave birth at another hospital and had a similar experience. She attempted to complete an incident report, which asked for very full details. However, she found it difficult to complete the form, which ran to several online pages. In the end she gave up.

This story illustrates the difficulty of reflecting the complexity of patient experience, and the many factors that contribute to it. Hazel's experience could be analysed as being made of two uncommon experiences: the mistake over the cord clip and the absence of the second midwife. Or it might be seen as the result of a deeper and more common problem, the breakdown of professional relations in a clinical team. An ideal system would be able to give Hazel the ability to record her perceptions of the underlying problem, and would also be able to spot patterns of apparently unrelated incidents that suggest that there might be a common, underlying problem in a particular care setting or team.

Involvement, Trust, Responsibility, Anonymity: Dr Abichal Shergill Kaur's story

Abichal is a GP in a busy city practice. She has been chosen as the patient safety lead partner by her colleagues. She wants to encourage

patients to become involved in helping the practice improve its patient safety practice by reporting incidents where they were harmed or felt at risk of harm. She drafts a letter to patients outlining a new reporting process and shares it with the practice meeting.

Her colleagues and the practice manager are not at all happy. The practice manager seems to see the new process as simply another way of complaining. "We already have a complaints process. Why do we need another one?" Abichal's colleagues suggest that to send such a letter would undermine trust in the practice. "We are more or less saying we are always making mistakes. Our patients trust us at the moment. Why do we want to spoil that?"

In Abichal's opinion, the practice manager has missed the point. With the complaints process, fairness means you have to spend so much time dealing with people's worries about their reputation. The patient safety reporting system she has in mind guarantees the anonymity of staff. Anyone can record an incident, knowing that the clinician or clinicians involved will remain anonymous. Abichal believes this is a good thing because it will be possible to focus on the safety issue.

When Abichal explains this to the patient forum at the practice, some of the members are very unimpressed. "If somebody has made a mistake, then people should know about that," says one member. "It's not about some sort of witch hunt. But they might need more training, or they might genuinely not be very good at their job. Personally, I wouldn't have confidence in a system which always protects the anonymity of professionals."

Abichal is unsure which way to turn. Despite all the views she has heard, she still believes that some sort of incident reporting system can make a major contribution to the quality of care at the practice. But she can see she still has a way to go before she can carry colleagues, the practice manager, and the patient representatives, with her on her project.

This story illustrates the following important question in incident reporting: who owns the experience, once it has been reported? If the report comes from the patient, then the experience clearly belongs to them – it is their story. But once professionals start to work with the implications of the experience and to reflect on what can be learned, then they begin to own, if not the original experience, then at least the learning involved in it.

Delegates were very clear that a reported incident belongs to everyone, but not in the same way. The same experience will have different implications for different people: patients, doctors, nurses and managers. What is important is that each person owns their own aspects of the experience and is responsible for putting the learning into practice.

4 Patient perspectives

At the workshop, delegates discussed their own experience in the light of the case studies and the analyses summarised above.

They highlighted two major obstacles encountered by patients in reporting their own experience:

- NHS care is often complex, involving many organisations and individuals. This is particularly so for long term conditions, including mental health issues. It is often difficult to know where to take a report
- Current processes mean that patients have to decide, before they report, what their experience means, so that they can use the correct process. For example, the process for making a complaint is different to the one used for reporting a safety concern, and different again from the process for making a positive comment

They also noted that the concept of “patient safety” has a different meaning depending on the level at which you view it. NHS England’s working definition of Patient Safety is “the avoidance of unintended or unexpected harm during the provision of healthcare.” This definition reflects NHS England’s role as a system leader and commissioner. It focuses on the outcomes of the whole system. At local level, the focus may be more on the working environment: sufficient numbers of staff with clear roles and responsibilities, and access to the appropriate equipment and medication required to deliver high-quality care. Both of these perspectives are needed to gain the whole picture.

For these reasons, delegates agreed that the key move for the new system should be to create a way of patients reporting all experience. Rather than predetermining what the eventual learning might be, what kinds of follow-up might be needed, and who would be responsible for that follow-up, delegates wanted a system capable of handling the “four C’s” of customer experience:

- Complaints
- Concerns
- Comments
- Compliments

They drew an analogy with clinical care. In clinical care, a presenting problem (the experience) is assessed and the patient is referred on for appropriate treatment. At each step, in theory at least, it is clear who is responsible for which aspect of care, and who has overall responsibility. The patient does not need to know what is wrong with them to access the care they need.

In the same way, a patient’s experience needs to be analysed and assessed by each relevant discipline and organisation. IT systems need to provide a means to track the assessment of the incident and to log the learning and the actions taken, together with the accountable person in each case. As with clinical care, the process needs to start in the same place regardless of the eventual outcomes.

Pushing the analogy further, and moving on to practicalities, delegates felt that it should be a responsibility of commissioners to ensure that there is such a “one-stop shop” for reporting patient experience, and that this experience is routed to the appropriate providers. Just as local commissioners are responsible for orchestrating a coherent pattern of care in their area, so they should use the contracting process to implement a locally coherent reporting system which all providers can connect to and use. They saw it as a natural part of the commissioning process to ensure that there is an adequate incident reporting system that takes account of the fact that NHS care involves many organisations.

Once an incident has been reported, there should be a tracked process recording the stages of analysis and change:

- What factors contributed to the failure in a duty of care?
- What can be learned?
- What actions will be taken to prevent a repetition?
- What actions have been taken?
- How have outcomes changed as a result of those actions?

Such a system would encourage patients to report experience because they would:

- not have to work out where and how to report
- be able to see that their experience was being made use of
- know that people were held accountable for learning from experience

Nevertheless, delegates felt that some patients would always need support to report their experience, so that the work of PALS and similar teams would continue to play a role. Some delegates felt that it was important to be able to report in free text so that the whole story can come across. Some felt that some patients would continue to need a route that did not rely on computers.

Delegates observed that, in addition to the challenges of process, which were somewhat addressed in the conversations at the workshop, the NHS faces a significant cultural challenge. It needs to move from a bureaucratic and defensive stance to a more open, transparent and responsive one.

Some delegates suggested that the well-being agenda would provide a useful impetus to this cultural change. In the well-being agenda, patients are being encouraged to take responsibility for their own health and well-being, and to become commissioners of their own care. Taking responsibility for reporting their experience of care falls naturally into this wider cultural shift, delegates felt.

5 Conclusion

This event was one stage in a cumulative process towards a successor NRLS. Two sessions for professional users of the NRLS will immediately follow this workshop for patient advocates; the learning from each workshop will form the starting point for the next. The conclusions of all three sessions will inform the development of the options

for a new system. Stakeholders will be kept informed of progress toward this, and will have further opportunities to comment on the plans as they mature.

As can be seen from this report, this was a lively and energetic workshop with a good deal of creative and strategic thinking. Delegates agreed to take the thinking further and to develop it within their own networks, including disseminating this document.

Appendix 2: workshop evaluations

This appendix summarises the combined feedback from the two parallel events on 21st and 28th, with thanks to the delegates for their valued feedback.

