

What every healthcare board needs to understand about patient safety

A report from the Good Governance Institute by
Andrew Corbett-Nolan and Jonathan Hazan

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This report is part of a growing series of reports developed by the Good Governance Institute in partnership with others that consider issues contributing to the better governance of healthcare organisations. We would especially like to thank Datix Limited for making available by an educational grant the resources to enable this report to be developed and distributed, and the Institute of Healthcare Management for help in promoting the report and its findings to healthcare managers and boards. The Maturity Matrix uses the style readers will be familiar with from our work and is used under licence from the Benchmarking Institute who originated this approach.

Other recent Good Governance Institute reports consider clinical audit, the governance of community services provider units, the board assurance framework, diabetes services, better practice in treatment decision making, integrated governance and governance between organisations.

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The Good Governance Institute is committed to develop and promote the Good Governance Body of Knowledge

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Introduction

We have written this report for all members of boards of healthcare organisations, but particularly for non-executive directors and others who may not be steeped in the world of patient safety. NHS boards hold the ultimate responsibility for the common law ‘duty of care’ for those who seek and use our services. The Health Act 1999 also applied a ‘duty of quality’ to all parts of the NHS and to all those who commission, provide or manage patient care. Under the Act, arrangements must be put in place for monitoring and improving the quality of the health care that health authorities and Trusts provide. Chief Executives are accountable for assuring the quality of NHS Trust services and must provide boards with regular reports on quality in the same way as they do for finance. This report aims to explain the importance of patient safety, the scale and nature of the epidemic of clinical errors, how the NHS has responded to this and what good governance practice is in relation to sustaining local improvement.

Harm done to patients by the healthcare system is as old as medicine itself. Healthcare is a high-risk industry, but surprisingly the scale of this harm has only really been understood within the past 20 years. Put simply, adverse events may account for the deaths of in excess of 30,000 NHS patients each year. This in itself is quite sufficient to make safety the prime duty of all on NHS boards, but there is more still to be gained from a better grip on safety than tackling this major public health issue. Understanding errors and addressing their causes provide a window into the efficiency and effectiveness of the whole healthcare system, and at a time when those on NHS boards are seeking to finesse better value for money and at the same time improve patient experience, there is a unique win-win to be had by putting safety first.

We developed our thinking in a number of ways. Both the Good Governance Institute and Datix have been involved in patient safety work for many years, and so we come to this task from having both a long-term commitment to the issue and having seen patient safety work in the United Kingdom develop over the last two decades. We have also considered the research base, the work of other organisations committed to improvement and the various national programmes aimed at helping boards institute better patient safety practice. We have also involved many from the NHS itself, and supported this work through a series of events looking at the issue from the perspectives of primary care, acute and community services, mental health services and commissioning. Our findings were reviewed at a symposium at the Royal Society of Medicine in London in January 2010. We would like to record our thanks to all involved in shaping, testing and challenging our ideas and proposals and in particular Dr. John Bullivant who reviewed and quality assured the final draft of the report.

We thus set our proposals for change in the context of how the patient safety movement has developed over the past two decades. This report additionally starts to rehearse some of those things that are known to improve safety, and are within the gift of the board. This includes our suggestion for the kinds of things which boards should be keeping a firm grip on. We have also developed a patient safety ‘ready-reckoner’ or maturity matrix¹ as a means by which a board can self-evaluate where its patient safety efforts stand in relation to our recommendations and what actions it could institute.

1 Maturity matrices have been developed as an improvement tool by the Benchmarking Institute

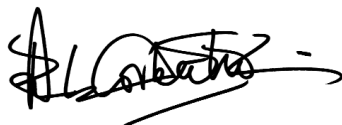
The matrix covers:

- Incident reporting and management
- Board reports and debate
- Director development
- Governance activities, structures and risk expertise
- Finance and commissioning
- Governance between Organisations (GBO) and partnerships

Improving the safety and quality of care services is nothing short of an odyssey. Anyone sitting on the board of an NHS organisation should understand the patient safety issue, and as a board member should be insisting that safety comes first. Boards should be laying out their own agenda for improvement and assurance, and monitoring progress and achievement.

2010 is the 10th Anniversary of the CMO Report 'An organisation with a memory' which identified the barriers to reducing the number of patient safety incidents.

We hope this short but timely paper helps board members to better understand the patient safety problem and their duties as directors, and starts to generate a better standard of discussion and challenge in regard to patient safety.



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January 2010

1 Why boards should focus on patient safety

The importance of patient safety as a key element of effective and efficient healthcare was identified as long ago as 1854 by Florence Nightingale in her well-known efforts to improve the military hospital at Scutari. She identified the significant effect that failure to attend to the basic elements of good care was having on morbidity and mortality, and that iatrogenic² harm was a more potent cause of illness and death to her patients than Russian sabres and bullets. Appalled at what she identified, she wrote “I think one’s feelings waste themselves in words; they ought to be distilled into actions which bring results”.³

The conditions at Scutari were extreme for sure, but not unique. Though in the century and a half since Nightingale’s work healthcare has been transformed, the harm done to patients by the healthcare system itself remains a very significant public health issue. In the United Kingdom around maybe as many as 34,000 deaths each year⁴ are attributable to errors in the healthcare system, making this nationally the third most potent cause of death after heart disease and cancer. This figure does not take account of around 25,000 people who die each year as a result of venous thromboembolism, many of which are as a result of healthcare interventions for surgery and medical care.⁵

The United Kingdom is no worse, and indeed may be better, than other Western countries. International studies all give similar figures to the UK’s 10% of all patients experiencing an adverse incident. Healthcare is, quite simply, a high-risk industry. Though we think of hospitals as places of safety, and are dismayed when the healthcare system causes harm, it is in fact common sense to consider that clinical care carries significant risks. Patients are often vulnerable and, by definition, sick. To effect cure, clinicians often need to do extreme things to their patients. They render them unconscious and cut them open. They feed the sick drugs so potent that only a qualified professional may prescribe them. The weakest patients are corralled together in hospitals in close proximity with other sick and possibly infectious patients in hospitals. And the most at-risk mentally ill patients are deprived of their freedom and locked up with others we deem insane.

Healthcare systems and processes are also complex. A single episode of care may be managed by various organisations and many professionals, and have a plethora of handover points within the care process. Risk management within industry helps us understand that it is handover points or discontinuities within a system that increase the potential for mishaps. Important parts of the care process may be outside a structured system.

And where there is a system, or an instituted and evidence-based way of providing care, this itself is subject to rapid change. As clinical knowledge expands and new and more appropriate treatments are developed, the training of those providing care is out of date almost at the moment of qualification. As healthcare organisations shape and construct new and better pathways in an effort to improve patient experience and opportunity, even where there is a fairly stable clinical approach to care, local arrangements may be changed week by week.

Keeping care safe and protecting patients from harm is thus no casual endeavour.

2 Iatrogenesis refers to inadvertent adverse effects or complications caused by or resulting from medical treatment or advice.

3 Edward Tyas Cook, *The Life of Florence Nightingale*, 1914

4 National Audit Office, *A Safer Place for Patients: Learning to improve patient safety*, 2005

5 National Collaborating Centre for Acute Care, *Venous Thromboembolism: Reducing the risk of venous thromboembolism in patients undergoing surgery*, National Collaborating Centre for Acute Care at the Royal College of Surgeons of England 2007

Those charged with governing healthcare organisations need to understand the importance of maximising protection from iatrogenic harm and, when it does occur, to minimise its effects. Nightingale also wrote “It may seem a strange principal to enunciate as the very first requirement in a hospital is that it should do the sick no harm”.⁶ Additionally, boards of NHS organisations are stewards of public money. Evaluating the non-human costs of clinical errors and adverse events is an imprecise science, but figures as high for system waste as around 25% of all healthcare costs arising from process failures are canvassed.⁷ In terms of direct costs, additional bed days arising from clinical errors are thought to be about £2 billion within the NHS, healthcare associated infections add another £1 billion to this and outstanding negligence claims in 2003/4 were in excess of £2 billion.⁸ In 2008/9 the NHS spent £79,000 per hour on clinical negligence.

6 Florence Nightingale, *Notes on Hospitals (3rd edition)*, 1863

7 R Harris and C Slipher, *Transforming healthcare: identifying the failures and unlocking the potential of our current system*, 2009

8 National Audit Office, *Ibid*

2 The patient safety system in the United Kingdom

The NHS is considered a world leader in understanding and addressing what is, as has been discussed, an international problem. Though the first serious studies to help understand adverse events were undertaken largely in the United States,⁹ the near-monopoly of healthcare provision in the United Kingdom provided an opportunity for national action. In 2000 the Chief Medical Officer published 'An organisation with a memory'¹⁰ which brought the academic literature on patient safety to a wider audience and identified the barriers to reducing the number of patient safety incidents.

By this time NHS organisations were already systematically seeking to locally report patient safety incidents and to feed these into clinical risk management systems of one sort or another. Incident reporting systems had, in the main, grown from either the enthusiasm of individuals interested in clinical risk management or efforts to predict and control cases with a potential for litigation.

The 'insurance' arrangements for the NHS in England in respect of clinical negligence claims, now organised by the NHS Litigation Authority, is a mutual system called the Clinical Negligence Scheme for Trusts (CNST). Since 1995 the CNST has evaluated premiums for member NHS organisations against a number of criteria, but critically including the maturity of clinical risk management arrangements through the achievement of a series of standards. Put crudely, the higher the level of standards achievement the lower the premium required. These standards included measures of good reporting practice, incident investigation and incident management. In almost all organisations these activities were supported by the use of information technology to a greater or lesser degree. The most widely used of these systems is Datix, now used by around 75% of all NHS organisations.

The first decade of this century also saw a burgeoning interest in the use of quality management to help improve efficiency, effectiveness and patient experience. 'Clinical governance', as this is termed, is in effect a call to arms for quality care. This meant that local interest in using quality management to solve the long-term problems of all healthcare systems was combined in England with fairly significant central support in the form of various Government agencies, such as the NHS Modernisation Agency and its successors, independent work from organisations such as the Health Foundation and improvement programmes developed by professional bodies such as the Royal College of Nursing and the Medical Royal Colleges. Interest in clinical risk management, learning from incidents and making care systems safer and more reliable were common features to all these programmes.

The development of clinical risk management was also prompted by the first national healthcare 'regulator', the Commission for Health Improvement (CHI). CHI was set up under the Health Act 1999 and from 2001 carried out local clinical governance reviews of NHS organisations. Credible clinical risk management systems were required as a fundamental element of clinical governance. This regulation function in England has been reorganised several times in the past decade and is currently the responsibility of the Care Quality Commission (CQC). All healthcare providing

9 L Kohn, J Corrigan and M Donaldson (editors), *To Err Is Human: Building a Safer Health System*, Institute of Medicine, 1999

10 Sir Liam Donaldson, "An organisation with a memory", Department of Health 2000

organisations, both NHS and independent sector, will be held to account against a common set of national regulations and supporting guidance.¹¹ These regulations, set by Parliament, form the basis for healthcare provider registration, and require a systematic approach to patient safety. In Scotland NHS Quality Improvement Scotland and in Wales the Healthcare Inspectorate Wales undertake the regulation function for NHS healthcare organisations and place equal stress on patient safety issues.

Thus by the time of the Chief Medical Officer's report in 2000 the NHS had been working at a local level to institute clinical risk management. But more was to come, with the Department of Health issuing 'Building a safer NHS for patients' in 2001.¹² This laid out a national agenda for promoting patient safety and aimed to encourage local learning through better incident reporting, investigation and management. It set up the National Patient Safety Agency (NPSA), which opened the same year and was charged with developing a national incident reporting system, assimilating other safety-related information and producing patient safety solutions. The NPSA now additionally manages the National Clinical Assessment Service and the National Research Ethics Service.

In 2006 the Health Act gave the Secretary of State the power to issue a Code of Practice for the Prevention and Control of Healthcare Associated Infections connected with NHS healthcare

Put simply, clinical risk management and efforts to improve patient safety have been developing now for around 20 years. This has grown from a number of roots, including local interest, reducing exposure to negligence claims, better quality management, the activities of the regulator and central leadership from the NPSA.

11 Care Quality Commission, 'Essential standards for quality and safety', 2009

12 Department of Health, 'Building a safer NHS', 2001

3 What works to improve safety in healthcare organisations?

Florence Nightingale, by attending to the basics of good nursing care, patient nutrition and comfort, hospital hygiene, better information systems and care planning dramatically lowered morbidity and mortality rates at the hospital at Scutari. By simply setting out clear expectations in the form of standards and insisting these were instituted and maintained, she made the hospital a safer place. She wrote ‘I attribute my success to this: I never gave or took an excuse’.

The patient safety movement itself was first organised by Boston surgeon Ernest Codman at the beginning of the 20th century. Codman began collecting and comparing the end results of care and publishing these,¹³ setting up the End Result Hospital in Boston as early as 1914. He tracked the longer-term outcomes of his patients, and drew on this experience to develop an approach to care standardisation. This programme was promoted by the American College of Surgeons and eventually became the Joint Commission on the Accreditation of Healthcare Organizations, the American healthcare regulator and an early champion of patient safety. Indeed, the Joint Commission work on sentinel events heavily informed the development of the patient safety movement in the United Kingdom.

Considerable attention has been paid since Codman’s early efforts to analysing the underlying causes of clinical errors. The issue had been looked at in many ways. Harm caused by individuals, where blame is appropriate, has been differentiated from that caused by the system, where a faulty or poorly designed process conspires to cause error producing inevitability. Failures have been considered either active, being proximate to the actual harm caused or latent, where the cause lies deep within the system itself causing errors lower down the management chain.¹⁴ Large-scale studies of healthcare associated harm reveal that most errors and adverse events have similar underlying causal factors and are usually the result of several such factors conspiring at the same time.^{15 16}

Issues identified include:

Communication – including staff induction, handover and transfer of care

Human error – complication of, or failure in, the technical performance of an indicated procedure/operation

Delay – either diagnosis or treatment or both

Treatment – no or inadequate or wrong or inappropriate treatment

Investigation – investigation inappropriate, not performed or not acted on

¹³ E A Codman, *A study of hospital efficiency*, Boston 1916

¹⁴ J Reason, *Human Error: models and management*, British Medical Journal 2000

¹⁵ Wilson, Harrison, Gibberd and Hamilton, *An analysis of adverse events from the in Australian Health Care Study*, Medical Journal of Australia 1999

¹⁶ R Croteau, *Poor communication is common cause of errors*, HealthCare Benchmarks and Quality Improvement, 2002

Error causes have also been explained as:¹⁷

Organisational or management factors – resources, organisational constraints, standards, targets and culture

Work environment – staffing levels, skills mix, shift patterns, design, availability and maintenance of equipment

Team factors – communication, supervision, seeking help, team structure

Individual staff factors – knowledge and skills, motivation, physical and mental health

Task factors – task design and clarity of structure, availability and use of protocols, availability and accuracy of test results

Patient characteristics – condition (complexity and seriousness), language and communication, personality and social factors

This learning has led to a proliferation of similar approaches to instituting practices to improve safety within healthcare organisations. These include addressing the error-causing factors and result in remedies such as improved communication, better use of agreed standard operating procedures, simplification of tasks, supervision arrangements for junior staff, special attention to high risk patients and developing the safety culture. Some local organisations, such as Salford Royal NHS Trust, have made patient safety a prime focus and have put in place organised programmes to test and spread better safe care practice. The NPSA have published their ‘Seven Steps to Patient Safety’¹⁸ to help top management better address patient safety. The ‘seven steps’ are:

Building the safety culture

Leading and supporting staff

Integrating risk management activity

Promoting reporting

Involvement and communication with patients and the public

Learning and sharing safety lessons

Implementing solutions to prevent harm

The NPSA and others have built on this with a number of specific programmes, including the ‘Patient Safety First Campaign’. Appendix 1 details important national campaigns board members should be aware of, which either directly address patient safety from the board perspective or aim to improve the structure of care with better patient safety as a direct outcome.

17 C Vincent et al, *Framework for analysing risk and safety in clinical medicine*, British Medical journal 1998

18 *Seven Steps to Patient Safety*, National Patient Safety Agency, 2003

4 Governing patient safety

NHS boards have a number of fundamental governance responsibilities and duties. These have been drawn from better practice in commercial organisations and through various codes and requirements developed for the NHS context. The main facets of governance are:¹⁹

Vision	identifying what the point of the organisation is and what it aims to achieve
Strategy	the plan to deliver the vision
Leadership	supporting how the organisation is directed to fulfil the strategy
Assurance	continual vigilance to ensure that plans are delivered and that all relevant compliances are maintained
Probity	that the organisation is run in an open, transparent and ethical manner and in line with Nolan principles

Through the lens of patient safety, these responsibilities include:

- Ensuring that when an incident occurs, it is properly reported, investigated and acted upon
- Reviewing management analyses of incidents and near-misses, to ensure that any quality problems have been identified and remedial steps are being taken to protect patients and the organisation
- Setting ambitious and meaningful targets for an overall reduction in harm, and ensuring that over time the organisation becomes a safer place for patients
- Ensuring that innovations and improvements with a proven link to safer care are systematically being implemented
- Because of the importance of patient safety, boards should receive a patient safety report at every meeting, just as they receive reports on finance and activity. We have developed a template board report to initiate debate and help boards up the standard of how patient safety issues are reported to them that addresses these issues. Reporting should be both quantitative and qualitative, having a narrative description of some of the management issues that any figures reveal. Our thinking behind recommending this template report is as follows:

Incident management – as we have discussed, hundreds of thousands of patient safety incidents occur in the NHS each year. From April 2010 reporting of all incidents to the NPSA is to be mandatory in England,²⁰ with this data being reviewed by CQC. Research consistently shows that patient safety incidents are under-reported.^{21, 22} Boards therefore need to ensure that they understand the completeness of their reporting practice and the extent of those incidents that are reported. Incident reports should then set in train a number of different responses, these ranging

19 'Integrated Governance: Delivering Reform on Two and a Half Days a Month, J Bullivant, A Corbett-Nolan and M Deighan, Health Finance Managers Association 2008

20 J Wise, *Reporting patient safety incidents to be mandatory*, British Medical Journal 2009

21 Panesar et al, *Reflections on the National Patient Safety Agency's database of medical errors*, Journal of the Royal Society of Medicine 2009

22 Parliamentary Health Select Committee. *Sixth Report – Patient Safety*, Parliament 2009

from communication to all those who need to understand that an incident has taken place (such as the referring clinician) through to incident investigation and potentially the preparation by the organisation for a claim or loss of contract income through the CQUIN regime. Appendix 2 details further issues relating to patient safety that board members should be aware of. Additionally it is important for boards to understand the global value (i.e. the total value across all activities) of episodes of care associated with an adverse event.

Incident patterns and quality problems – incident reporting is one critical means by which an organisation can tell whether it has some special cause quality problem. Once incident reporting is reliable and achieving good levels of completeness, the actual pattern of reported incidents and near misses can help an organisation understand the sufficiency and quality of the care process itself. However without sufficient sample size, reasonable completeness in reporting and a means of comparison with a norm, such information will be at best meaningless and at worst misleading. For this reason we would encourage boards not just to focus on the low number of more serious incidents, but to demand proper management analysis of statistically sound cohorts of material. Additionally, boards should not be the first place where this is reported and it is not for the board to spot the unusual trends. There should be a management process in place by which the patterns of incidents reported are evaluated. Boards should receive details of when there is a special cause variation that is statistically sound, together with details of management action to investigate further and ensure a return to safe practice. To be able to identify trends it is important to understand normative rates for particular kinds of error. These are potentially available from research or from comparison with other organisations, or indeed over time from one's own organisation. However, benchmarking to identify special cause factors is fraught with problems until the standard of incident reporting is significantly better. Benchmarking studies need to be precise and highly focussed to be valid.²³

Understanding success and harm reduction – the goals of any patient safety activity must be to first reduce harm to patients. However, patient safety should additionally improve the reliability and cost effectiveness of care processes themselves, and thus reduce waste within the system. Various tools are increasingly being used to help organisations understand whether they are making progress in terms of reducing harm. The Global Trigger Tool (GTT) is one such tool. Based on a retrospective analysis of case notes, the GTT identifies injury caused in a care process by identifying the signs of unintended harm. An example would be the use of Narcan, an antidote used after a patient is given an overdose of narcotics. Another GTT would be the onset of pneumonia in an in-patient setting, when that was not present in the patient on admission. The GTT thus is able to identify harm not reported through incident reporting. Boards should set themselves ambitious improvement targets for year on year harm reduction, and monitor progress towards these at every board meeting.

23 The Good Governance Institute has published the Benchmarking Institute's Code of Conduct for better practice in benchmarking activity

Systematic institution of safer practice and improvements – there is a good and growing evidence base for innovations and improvements that have a proven effect on patient safety. Boards need to be confident that their organisations are systematically instituting such improvements, spreading better practice and ensuring that where there is evidence of a safer care process it is being introduced. Examples of organisations that systematically monitor the introduction of innovation and evidence-based approaches to improvement include Royal Bolton Hospital NHS Foundation Trust. Bolton uses the lean management approach under their Bolton Improving Care System.

Board patient safety template report	
<p>Incident management</p> <p>Reported incidents compared to expected total</p> <p>Completeness of reporting</p> <p>Investigation and claims management</p> <p>Communication to relevant stakeholders</p> <p>Costs of reporting and investigations</p> <p>Total risk – global value of episodes of care associated with incidents</p> <p>Triangulation to other data sources, such as complaints, training, inquests</p> <p>Links to revalidation, credentialising, continuing professional development and appraisal</p>	<p>Incident patterns and quality problems</p> <p>Activity of management review of incidents</p> <p>Pattern of changes not yet associated with problems</p> <p>Any special cause variations identified</p> <p>Root causes of special cause variations</p> <p>Actions from special cause variations</p> <p>Trend analysis over time</p> <p>Benchmark data, where available</p>
<p>Harm reduction and resources saved</p> <p>Progress towards the organisation's harm reduction target</p> <p>GTT or similar programme details, including numbers of case notes reviewed, service under study</p> <p>Results and trends</p> <p>Reductions in same cause incidents</p> <p>Resources lost to clinical errors, e.g. additional bed days arising from adverse events</p>	<p>Instituting improvement</p> <p>Improvements and innovations instituted</p> <p>Care pathway redesign</p> <p>Proportion and value of care under evidence-based guidelines</p> <p>Links to clinical audit findings, including local results from national comparative audits</p> <p>Participation in national and local patient safety campaigns</p>

5 Recommendations and how your organisation stacks up

In the course of developing this report we were able to review and discuss many of the improvements being planned in various healthcare organisations. Many of these we recommend for universal uptake. To help board members quickly understand how their organisation stacks up we have also developed a maturity matrix – see Appendix 3 – which helps you to quickly understand how your organisation is progressing with implementing these recommendations of better practice which cover:

- Incident reporting and management
- Board reports and debate
- Director development
- Governance activities, structures and risk expertise
- Finance and commissioning
- Governance between Organisations (GBO) and partnerships

In using this tool it is important to be summative – in other words to be at level three, one must have achieved levels one and two also, and so on.

Incident reporting and management

- All providers of health and social care services should have in place incident reporting and management systems, whether they are NHS, private or third sector organisations
- Web-based systems should replace manual processes to enable healthcare organisations to ensure better access to incident reporting
- Patients should have the means to report when they believe an adverse event has taken place, without needing to resort to the complaints process
- Organisations should ensure that details of an adverse event or a near miss are communicated to the referring clinician
- Organisations should be able to monitor incident management by having access to information on the current stages of all incidents in the incident management process.
- Incident management systems should be flexible and able to relate to other systems that control risk reduction and safety improvement mediations, such as training, continuing professional development, revalidation, credentialising and appraisals
- Incident reporting systems should be capable of directly relating to prime governance instruments, such as the risk register and Board Assurance Framework
- Organisations should use a range of appropriate incident investigation methods, not over-relying on any one approach alone. Specialist risk management staff and others (for example, clinicians) involved in incident investigation should have access to a range of training, where possible from different training providers
- Investigation reports should be subject to systematic quality review processes
- Investigation reports should be written in plain English and understandable by lay persons as well as risk specialists and clinicians

Board reports and debate

- Boards should consider patient safety at every board meeting
- Patient safety should be the first item the board considers
- Standard board reports should answer:
 - Do we effectively and comprehensively manage those incidents that occur?

- Does our pattern of incidents and near-misses inform us of a special cause quality problem?
- Are we reducing harm to patients, and resources wasted by failure?
- Are we systematically instituting practices known to reduce harm and promote safer care?
- Boards should set a plan to integrate safety, financial and activity reporting and reports.
- Board reports should be statistically sound and explain variations in terms of whether or not these are within expected bounds
- Boards should decide on the means by which they understand the extent, nature and trajectory of harm, costs and waste caused by errors within their organisation
- Boards should set and systematically monitor progress towards their own improvement targets for patient safety. These should be ambitious and communicated to staff, commissioners and the local community
- Boards should understand their own exposure to risk at any given time and monitor how this changes over time
- Boards focus too much on individual serious untoward incidents (SUIs) and should systematically consider lower level but often more revealing patterns of adverse events and near misses

Director induction, training and continuing development

- All directors should receive awareness training to help them properly understand patient safety and risk in a healthcare context
- Director training should include the epidemiology of patient safety, the scale and costs of adverse events, factors that influence organisational safety, organisational culture and effective patient safety mediations, understanding statistical process control and other quality management methodologies and leadership of patient safety
- All board members should understand and be able to explain the significance of patient safety, national and local systems for safety and risk and their own organisation's safety improvement approach
- There should be greater clarification as to what the governance (as opposed to management) role in patient safety is
- All boards should routinely receive information about serious service failures in other organisations which may affect their own services, the approach of regulators or other significant compliance issues
- Board members should understand the range of investigation methods used in their own organisations
- Board members involved in any form of incident investigation or review should have access to training, especially when leading quasi-legal investigations

Governance structures and risk expertise

- All organisations should have governance systems and structures that enable the board to be properly assured on safety and risk issues. These should be periodically tested using walk-through or scenario exercises.
 - Patient safety reporting should be linked systematically to the risk register and Board Assurance Framework,
 - The risk register and Board Assurance Framework should recognise risks at the interface with partners and suppliers, that can also cause reputational risk
 - Risk experts within healthcare organisations should have greater access to the board
-

- All healthcare organisations need access to high-level expertise on risk. The role of the Chief Risk Officer, reporting directly to the board, should be considered
- In all organisations there should be a multi-disciplinary management group systematically reviewing incidents, near-misses, complaints and other indications of process failures and interpreting these for trends, special causes and patterns to routinely advise the board
- Management should triangulate information arising from adverse event and near miss reporting with other information, such as complaints, inquests, and claims, clinical audit and care pathway variations. Clinical audit is used strategically to provide assurance on board priorities
- Recent governance thinking (the Walker Report)²⁴ has rekindled the debate around whether boards should have a risk committee. Further thinking needs to be done on whether healthcare organisations should have a risk committee alongside the audit committee to better understand the risks and control of risk within the organisation. One Foundation Trust Chairman described the audit committee as focusing on the past and present and the risk committee as looking into the future.

Governance activities

- The board's own annual review should consider the treatment of safety issues
- The audit committee should assure the board that the organisation's patient safety system is reliable and fit for purpose
- The Chair's annual appraisal of all directors should include assurance that directors fully understand their role in patient safety and that all directors actively contribute to safety and risk issues

Finance and commissioning

- Patient safety should be used as one means by which organisations understand waste within their systems and processes
- Both commissioners and providers should have plans in place to understand the global value of those episodes of care associated with an adverse event. Any partnership or contract needs to deal explicitly with responsibility and liability and be reviewed as part of the contract.
- Patient care episodes associated with an adverse event should automatically be included in the monthly challenge list and fed into CQUIN discussions between commissioners and providers
- Contracts should encourage the sharing of information about patient safety, and specify responsibilities and liabilities

Governance Between Organisations (GBO)²⁵ and partnerships

- All boards should have a means of understanding and engaging with risks and safety issues at the boundaries of care and at handover points
- Any partnership arrangements should have in place a pre-agreed system for incident reporting and risk management and review
- The governing bodies on all partner arrangements should have access to information on reported incidents and near misses
- Boards cannot outsource reputational risk. Partnership arrangements should routinely include prospective plans for reporting, managing, investigating, reviewing, resolving and taking action on serious untoward incidents
- Recording systems must ensure that the referrers and external (e.g. joint or specialist) commissioners of patients receive feedback on adverse events affecting the patients referred

24 Sir David Walker, *Walker Review of Corporate Governance of UK Banking Industry*, HM Treasury 2009

25 *Governance Between Organisations (GBO) A debate paper* launched at NHS Confederation Conference 2008 and published by IHM

Appendix 1 – Campaigns and resources

Ten publications every NHS board member should read –

‘To err is human: building a safer health system’ (summary) – published in 1999. This seminal paper from the Institute of Medicine that brought initial high-level attention to the patient safety epidemic

‘An organisation with a memory’, the original report from the Chief Medical Officer for England published by the Department of Health in June 2000

‘Seven questions every board member should ask about patient safety’, published by the NPSA with support from the NHS Confederation and the Appointments Commission. This series separately addresses acute and primary providers and commissioners.

‘A Safer Place for Patients: Learning to improve patient safety’, the review of progress with the national programme for patient safety by the National Audit Office, 2005

‘Safe Today – Safer Tomorrow’, published by NHS Quality Improvement Scotland, January 2006

‘Research on assuring the Board that the care provided to patients is safe’ prepared for the Healthcare Commission and published in November 2008.

“‘Safe in the knowledge” – how do NHS trust boards ensure safe care for their patients?’, published by the Healthcare Commission March 2009

‘Health Committee – Sixth report. Patient Safety’ – published by Parliament in 2009

‘Clinical Audit: A simple guide for NHS Boards & partners’ by John Bullivant and Andrew Corbett-Nolan, published by HQIP, January 2010

‘Integrated Governance Volume 2 – Governance between Organisations’ to be published by HFMA, May 2010

Board members should ensure their organisations are involved in –

Patient Safety First is a programme from the NPSA, the NHS Institute for Innovation and Improvement and the Health Foundation. It aims to create a movement within healthcare organisations in England, with individual organisations being able to sign up and implement the various component elements of the campaign.
www.patientsafetyfirst.nhs.uk

1000 Lives Campaign is a pan-Wales programme to save 1000 lives from patient safety events by April 2010, and which promotes a series of life-savings interventions for healthcare organisations to implement
www.wales.nhs.uk/sites3/home.cfm?orgid=781

HSC Safety Forum is a programme focusing on improving patient safety in Northern Ireland.
www.hscsafetyforum.com

Scottish Patient Safety Alliance is a national approach to oversee the Scottish Patient Safety Programme
www.patientsafetyalliance.scot.nhs.uk

Appendix 2 – Contractual issues relating to patient safety

In England, the commissioning system is seeking to place greater emphasis on requiring commissioners to reward providers that ensure safe, quality service to patients and to penalise those that do not. Relevant terms all board members should be aware of are:

Never events – these are serious and largely preventable patient safety incidents that should not occur if the proper preventative measures have been implemented. Primary Care Trusts (PCTs) should monitor and publicly report on these on an annual basis. Providers should not be paid for episodes of care relating to a never event. Examples of never events include wrong site surgery, in-patient suicide using non-collapsible rails and intravenous administration of mis-selected concentrated potassium chloride.

CQUIN payments – Commissioning for Quality and Innovation is a programme under the standard national contract to enable commissioners to make a proportion of providers’ income contingent on quality and innovation. Under these arrangements, PCTs will set local quality targets, which should include matters relating to patient safety, such as the proper follow-up of incidents, implementing learning points and innovations designed to improve care services. PCTs could challenge for payment purposes episodes of care associated with an adverse event.

QIPP – Quality, Innovation, Productivity and Prevention is the national programme or mechanism in England for implementing the New Stage Review.²⁶

The governance of patient safety: Maturity Matrix

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To use the matrix: identify with a circle the level you believe your organisation has reached and then draw an arrow to the level you intend to reach in the next 12 months.

Progress levels ▶	0	1	2	3	4	5
Key Elements ▼	NO	Basic level Principle accepted and commitment to action	Early progress in development	Results being achieved	Maturity – comprehensive assurance in place	Exemplar
Incident reporting and management	NO	Incident reporting and management are monitored to ensure completeness and indicate management/investigation stages.	Incident reporting is web-based and includes reporting to referring clinicians. A variety of incident investigation approaches are used.	Incident reporting links to complaints, professional development, revalidation and appraisal. Reports indicate the reduction of some particular adverse events.	Patients may use the system to report alleged incidents. Reports indicate a reduction in harm for specific categories of patients. Patterns of incidents trigger clinical audit activity.	Incident reporting is undertaken on a whole care pathway basis. Harm reduction for specific categories of patients has been achieved for two consecutive years.
Boards reports and debate	NO	Patient safety is an agenda item at every board meeting. Reports cover incident reporting and management. Statistical variation is explained. The board has set patient safety improvement targets.	Board reports quantify harm, costs and waste.	Board reports include data that can be used to establish where incident/near miss patterns indicate quality issues.	Patient safety reports are linked to improvement activities. Information from incidents is triangulated with other data, including complaints, inquests and care process reviews.	Board reports include systematic information on the implementation of evidence-based safer practice. Safety, financial and activity reports are integrated.
Director development	NO	All directors have received awareness training. Contribution to patient safety is included in the annual appraisal process.	Board members involved in investigation processes have received training and their work is subject to quality review.	All board members can confidently explain patient safety issues and the approach to improvement of the organisation.	Board members have completed personal development objectives as identified in their appraisal process.	Board members regularly take part in the development of other directors/boards.
Governance activities structures and risk expertise	NO	The annual review of the board includes specific consideration of patient safety. Risk experts within the organisation have access to the board.	There is a multidisciplinary management group supporting the review of patient safety information for the board. The audit committee assures the board on the governance of risk.	Patient safety links systematically to the risk register and Board Assurance Framework.	The board has a Chief Risk Officer and a risk committee. Clinical audit is used strategically to provide assurance on board priorities.	Third parties use the organisation's governance arrangements for patient safety as an exemplar to others.
Finance and commissioning	NO	The patient safety element of the CQUIN regime has been discussed by the board. Details of adverse events are systematically shared with commissioners.	Patient safety is used as a means by which the organisation understands waste. The value of revenue at risk from never events is understood.	The global value of those episodes of care relating to an adverse event is understood.	Contracts have been gained as a result of the organisation's reputation for patient safety.	Resources lost due to adverse events have been reduced.
Governance Between Organisations (GBO) and partnerships	NO	The board understands its partnership arrangements and prospective risk arrangements are in place. These include incident reporting arrangements.	The board receives periodic reports on incidents arising from partnership arrangements.	The organisation reports safety feedback to partner organisations.	Harm has been reduced for certain categories of patients whose care is under partnership arrangements.	Residual risk from partnerships has been reduced for two consecutive years.

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