NHS Resolution

Taking action to improve patient safety in primary care

13th September 2024

NHS Resolution

@NHSResolution

Advise / Resolve / Learn

Welcome to today's programme:

Chair:

Samantha Thomas- Safety and learning lead - General Practice | NHS Resolution

Guest speakers:

Andrew Murphy-Pittock - Education Director, Health Services Safety Investigation Body
Dr Nick Woodier - Senior Safety Investigator, Health Services Safety Investigations Body
Dr Hester Wain - Head of Patient Safety Policy, NHS England
Dr Kiren Collison - Deputy Medical Director of Primary Care, NHS England
Mark Smith – National Patient Safety Partner, NHS England

Housekeeping rules for today's session

- Today's main session will be recorded
- Please note – you will receive a feedback survey after the session. This is for evaluation purposes, and we'd really appreciate your feedback.
- Please feel free to put comments and questions in the chat box

Intended learning outcomes

- To understand the link between complaints and clinical negligence claims to patient safety in Primary care
- To explain the role of the Health Services Safety Investigations Body (HSSIB) in primary care and provide examples of how they might utilise its resources to develop safety science skills in primary care.
- To be able to reference the NHS Primary Care Patient Safety Strategy and relate its relevance to their roles in primary care.

NHS Resolution

Taking action to improve patient safety in primary care

Samantha Thomas

- National safety & learning lead for general practice, NHS Resolution

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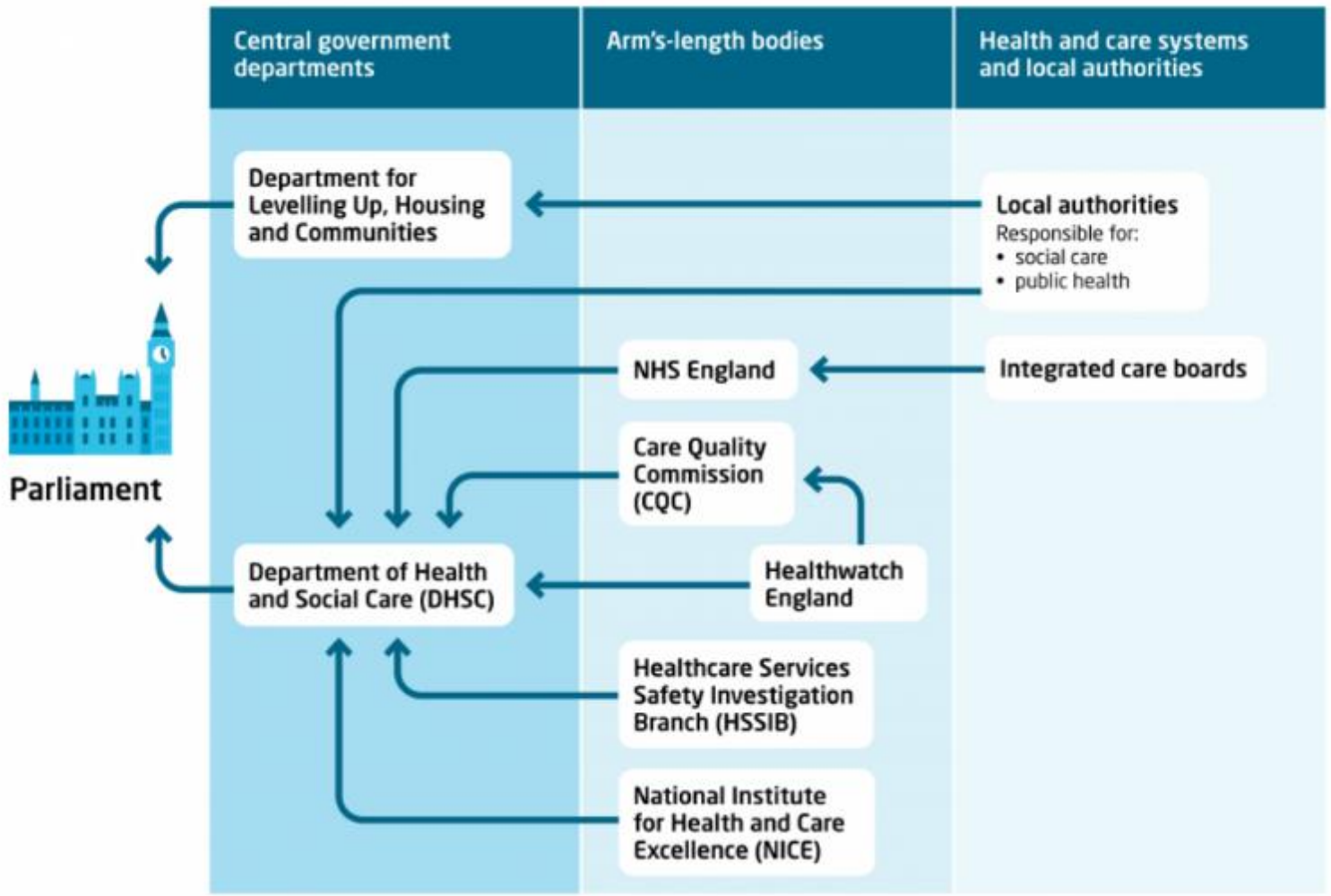
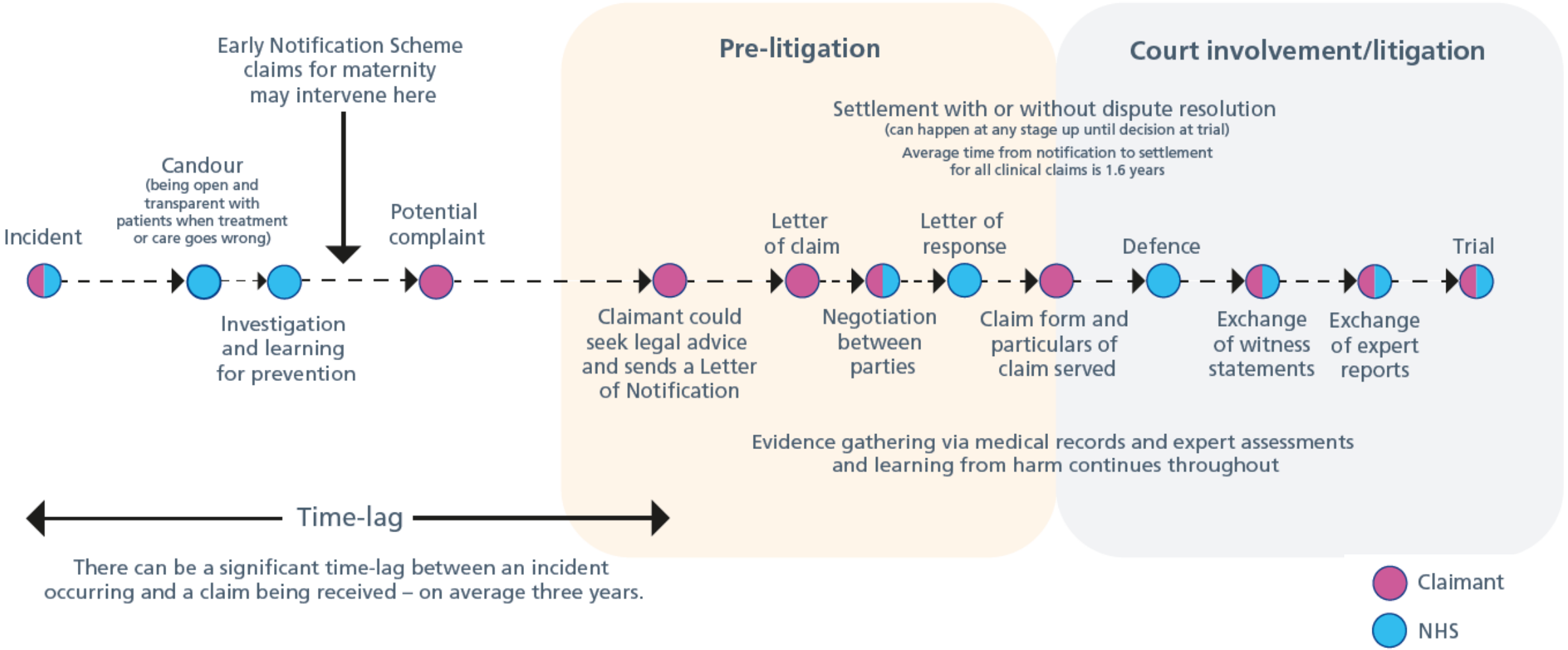
NHS Resolution and the wider system



The NHS Resolution Safety and Learning team supports the NHS to better understand their claims risk profiles, to target their safety activity and share learning across the system for improvement.

King's fund (2022) A simple guide to how accountability flows in health and social care in England

Claims life cycle



Incidents, complaints and claims

1 April 2023- 31 March 2024

13,718

new clinical claims

reported to NHS Resolution

229,458 **complaints***

recorded by NHS Digital

2,345,817 **incidents****

reported to the National Reporting and Learning System

* 1 April 2022-31 March 2023 data** 1 April 2021-31 March 2022 data

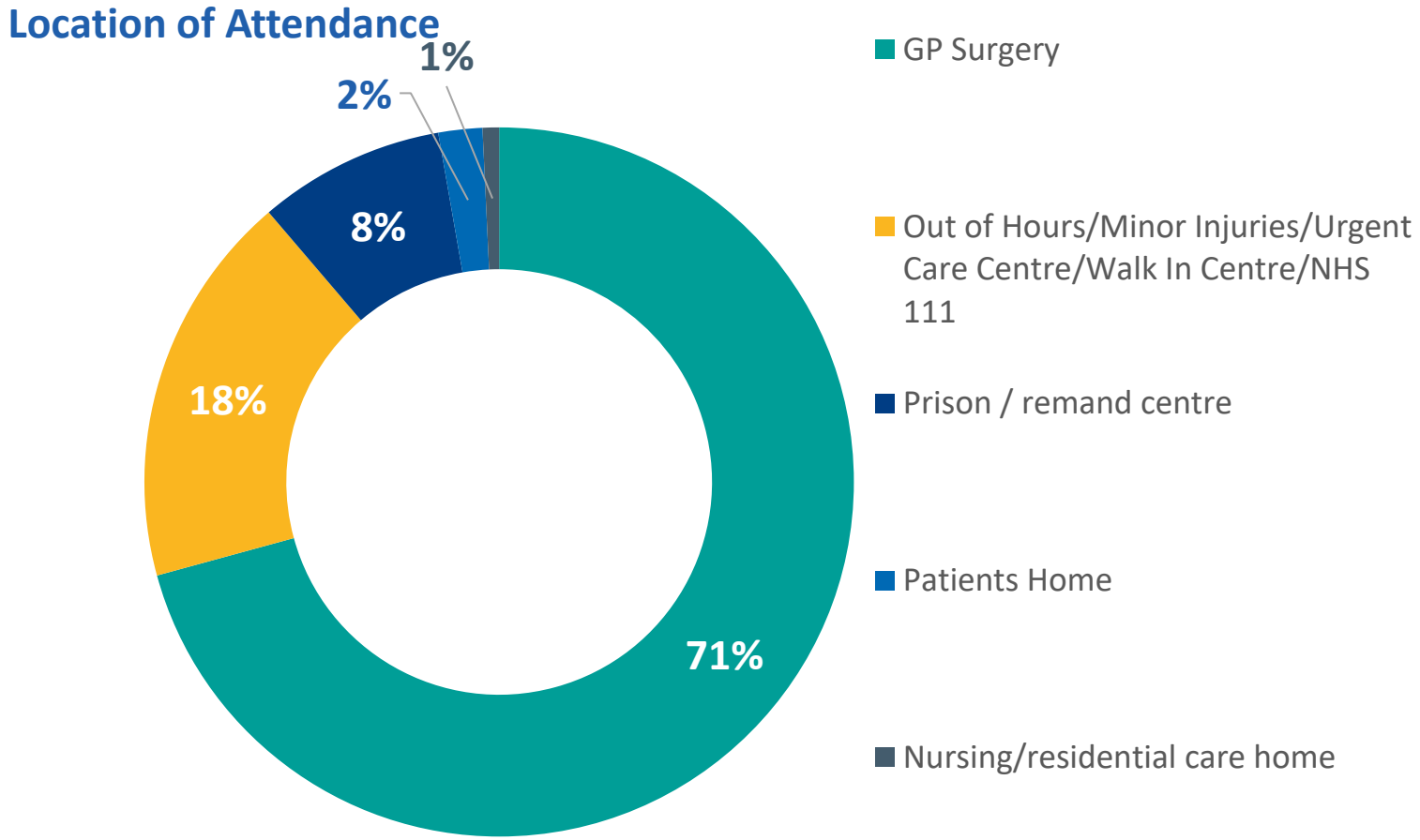
Clinical negligence scheme for general practice (CNSGP) report

Failure to investigate and/or diagnose, and missed, wrong and delayed diagnoses

Medication errors

Delays in care, including specialty reviews and referrals

Problems with communication, between primary and secondary care



Illustrative case study

As you read about this incident, please ask yourself;

- Could this happen in my organisation?
- Who could I share this with?
- What can we learn from this?

A man in his 30s called the GP surgery and requested an appointment. He gave his symptoms as chest pain with dizziness and strange sensations in his shoulders. He was told no appointments were available that day and to ring back the following day.

The patient's wife attended the surgery in person the following day and a same day appointment was made. The patient was seen by a newly qualified non-GP staff member with the wife present. A discussion with the supervising doctor took place and the patient was advised that they would book an ECG and a follow up appointment.
The patient died at home the following day. Cause of death: heart attack

Points for reflection:

- Do you have a process for documenting appointment queries?
- Do you consider duty doctor or advice to go to hospital as patient advice?

Do you regularly review the red flag symptoms process?

Taking action to improve patient safety in primary care

Andrew Murphy-Pittock
Education Director, Health Services Safety Investigations Body
Dr Nick Woodier
Senior Safety investigator, Health Services Safety Investigations Body

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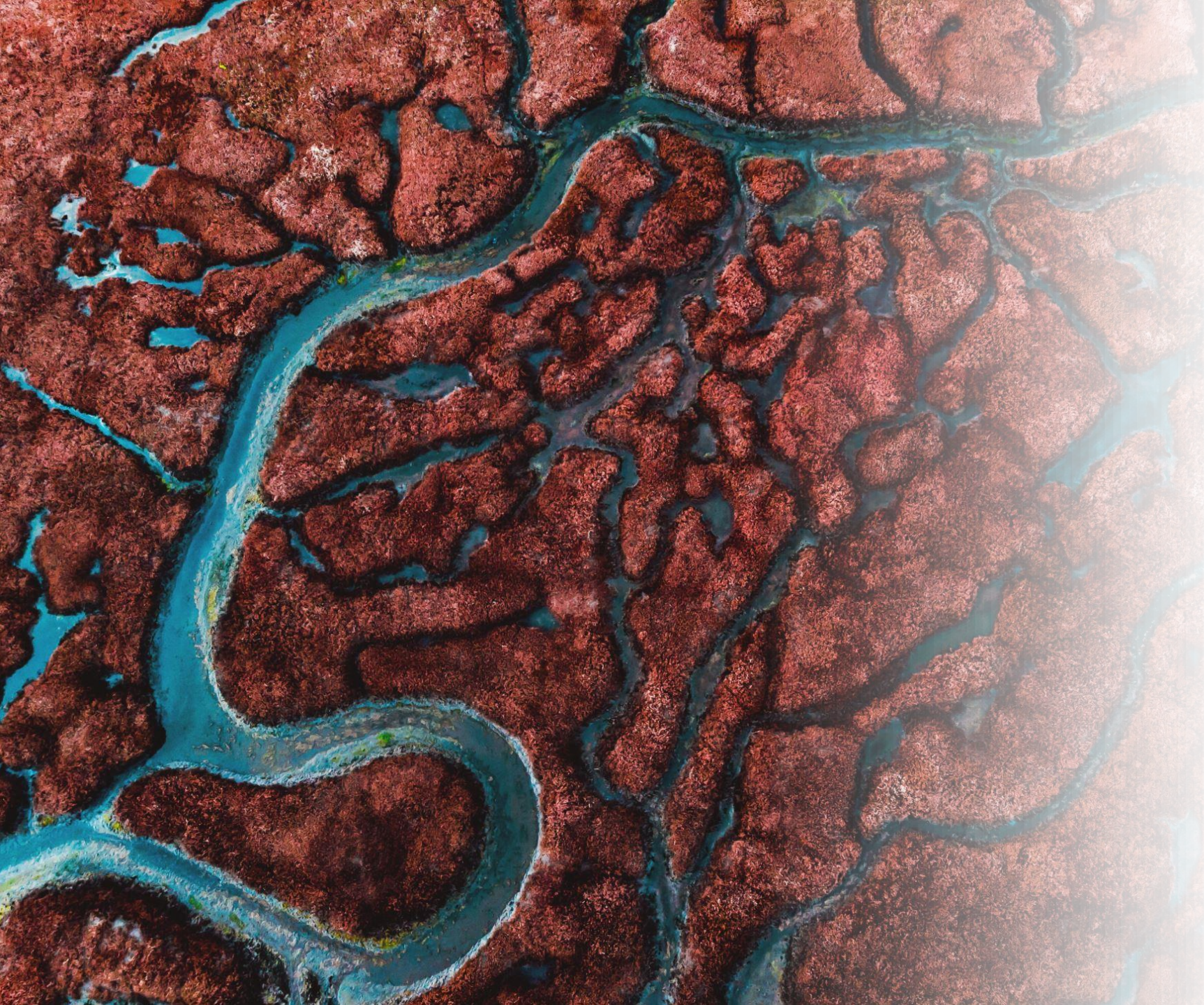
Health Services Safety Investigations Body

Moving upstream; an introduction to HSSIB

Andrew Murphy-Pittock, Education Director

Dr Nick Woodier, Senior Safety Investigator

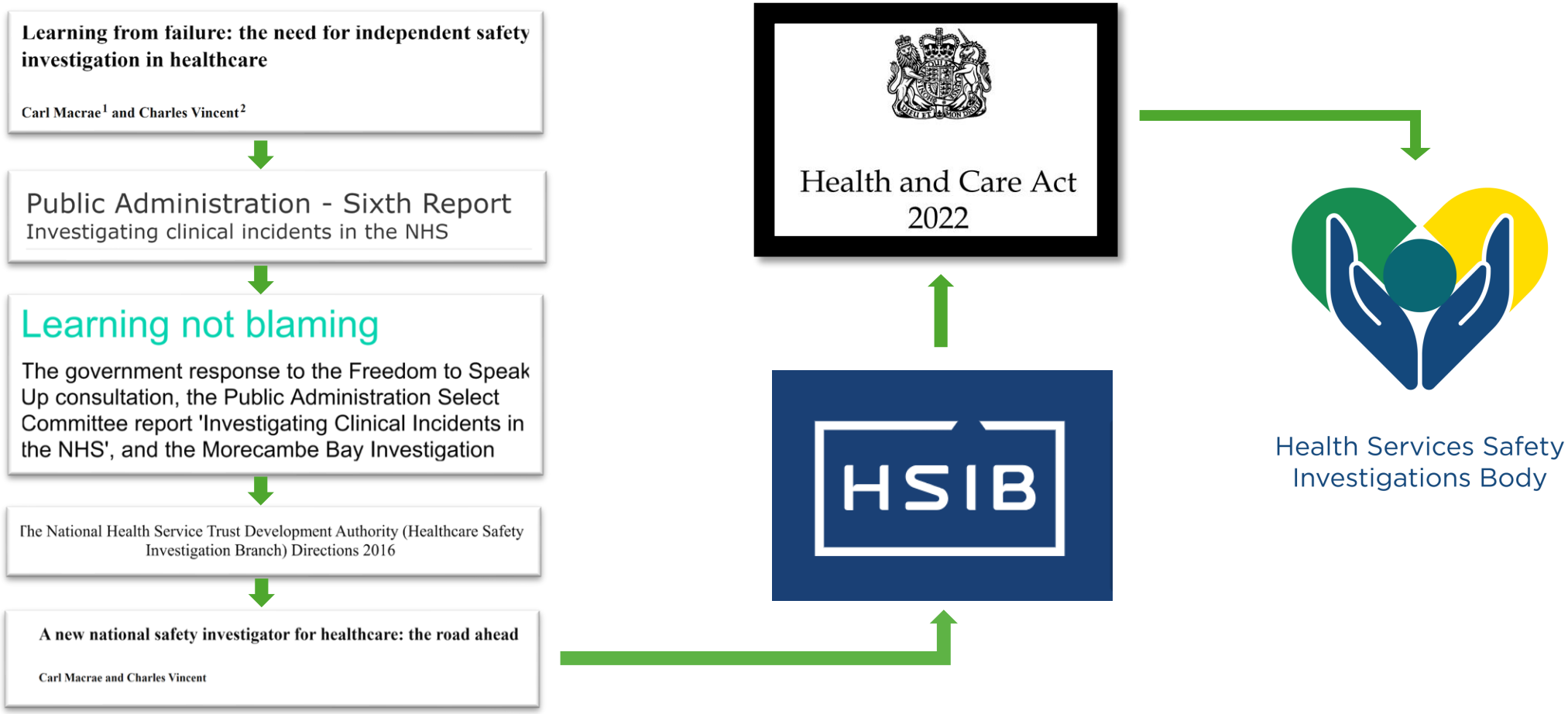


There comes a point where we need to stop just pulling people out of the river. We need to go upstream and find out why they're falling in.

Our mission

To lead and promote healthcare safety excellence and learning through investigation, education and collaboration.

Our evolution



Economics of patient safety

3 million deaths globally – equivalent to HIV/AIDS

Patient harm slows global economic growth by 0.7% per year

Direct cost of unsafe care – 13% in developed nations

$606 billion per year

1% of the combined economic output of OECD countries

Most cost-effective: multi-modal approaches that align clinical, corporate and professional risk across system silos

Medication error in England

237 million errors annually

66 million potentially clinically significant

Direct cost of medication error £98m:

- 181,626 bed days
- Causing or contributing to 1708 deaths

What we do – investigation

HSSIB investigates incidents that “occur in England during the provision of health care services and have or may have implications for the safety of patients” – focus is on complex patient safety risks where an investigation could lead to national learning.
HSSIB investigations **DO NOT** apportion **BLAME**, **LIABILITY**, or determine **WHETHER REGULATORY ACTION SHOULD BE TAKEN** and information we receive is **PROTECTED BY LAW.**
HSSIB can investigate NHS and independent healthcare where “the systems and practices in the provision of NHS services could be improved.”
HSSIB investigations do not replace any existing investigation or regulatory processes.
HSSIB investigations may make recommendations for improvement – made to national organisations to encourage nationwide impact and learning.

Upcoming HSSIB work…

Digital Tools for Online Consultation in General Practice
August 2024

Healthcare Provision in Prisons: Emergency Care
August 2024

Workforce and Patient Safety: Temporary Staff Integration
September 2024

Mental Health Inpatient: Learning from Deaths/ Workforce and working conditions
October 2024

Time critical medications and ePMA

Inpatient Mental Health Care

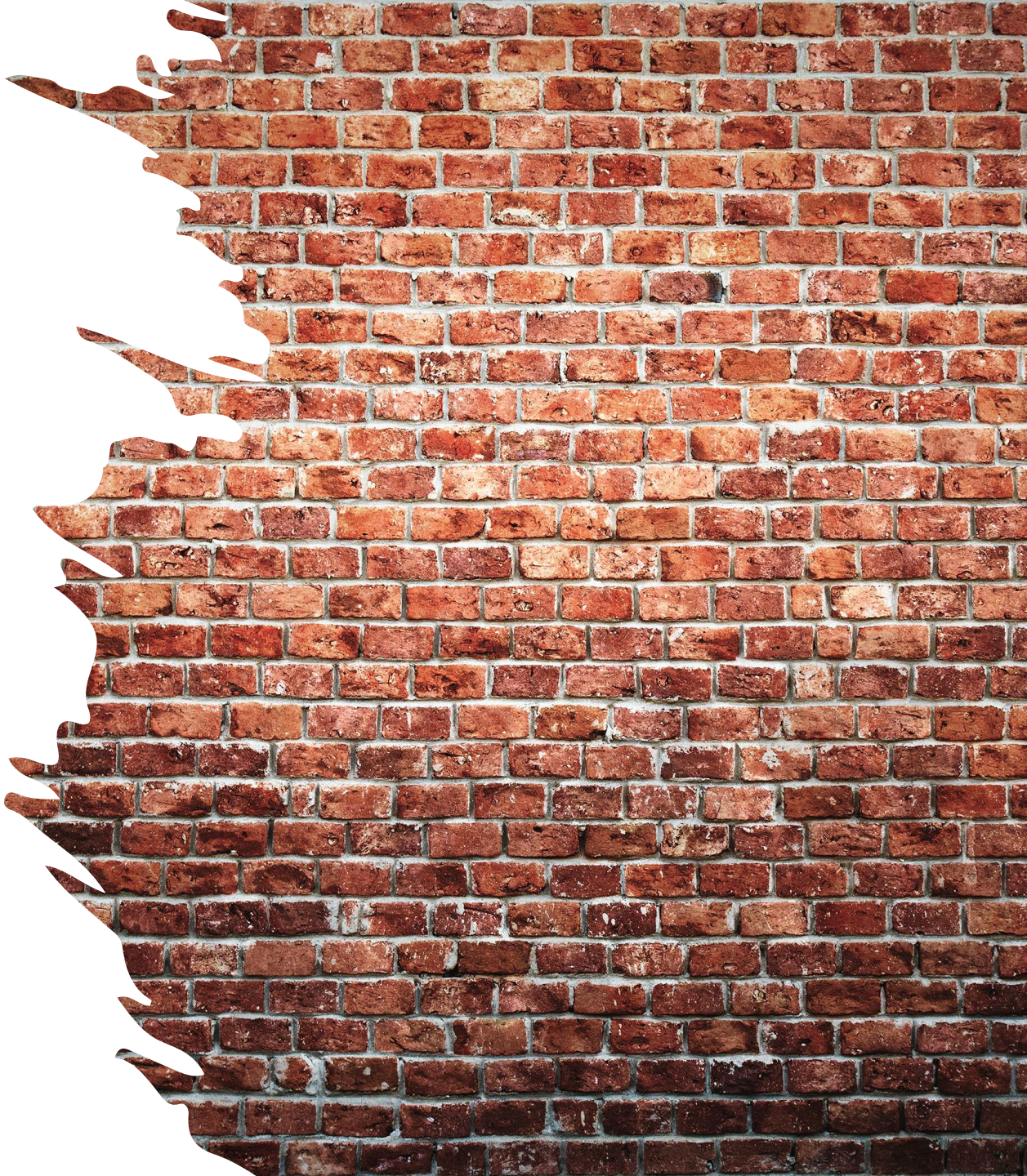
Workforce/Safety in Primary Care

Fatigue

Safety Management Systems

We don’t need no education

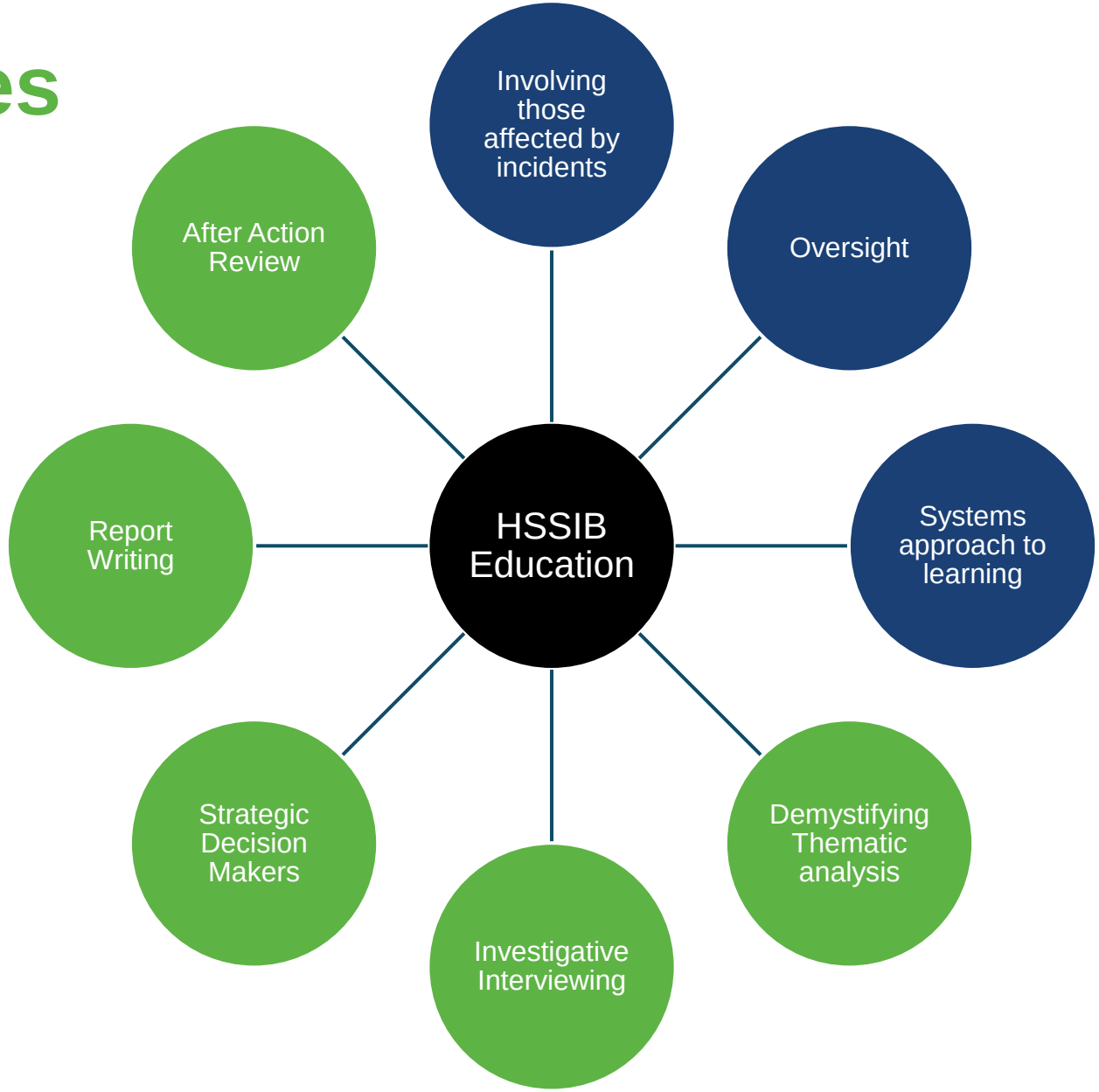
- Learning from our processes
- Learning through safety science
- Human factors assemble!
- A systems approach
- Collegial and practical development
- Critical friends and responsiveness
- Recognition



What we do – education

Our Education Programmes Support a professional approach to healthcare safety investigations and enable learning from patient safety incidents.
Our courses are primarily aimed at staff in health and social care settings, who are involved in safety investigations for learning.
We have worked closely with colleagues at NHS England to ensure our training meets Patient Safety Incident Response Framework (PSIRF) requirements.
Our flagship programme, the CPD accredited ‘A systems approach to investigating and learning from patient safety incidents’, is on-demand learning and we can accommodate large numbers of leaners in each cohort.

Education programmes



Patient safety investigations

Quick find:

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Continuity of care: delayed diagnosis in GP practices

PUBLISHED NOVEMBER 2023

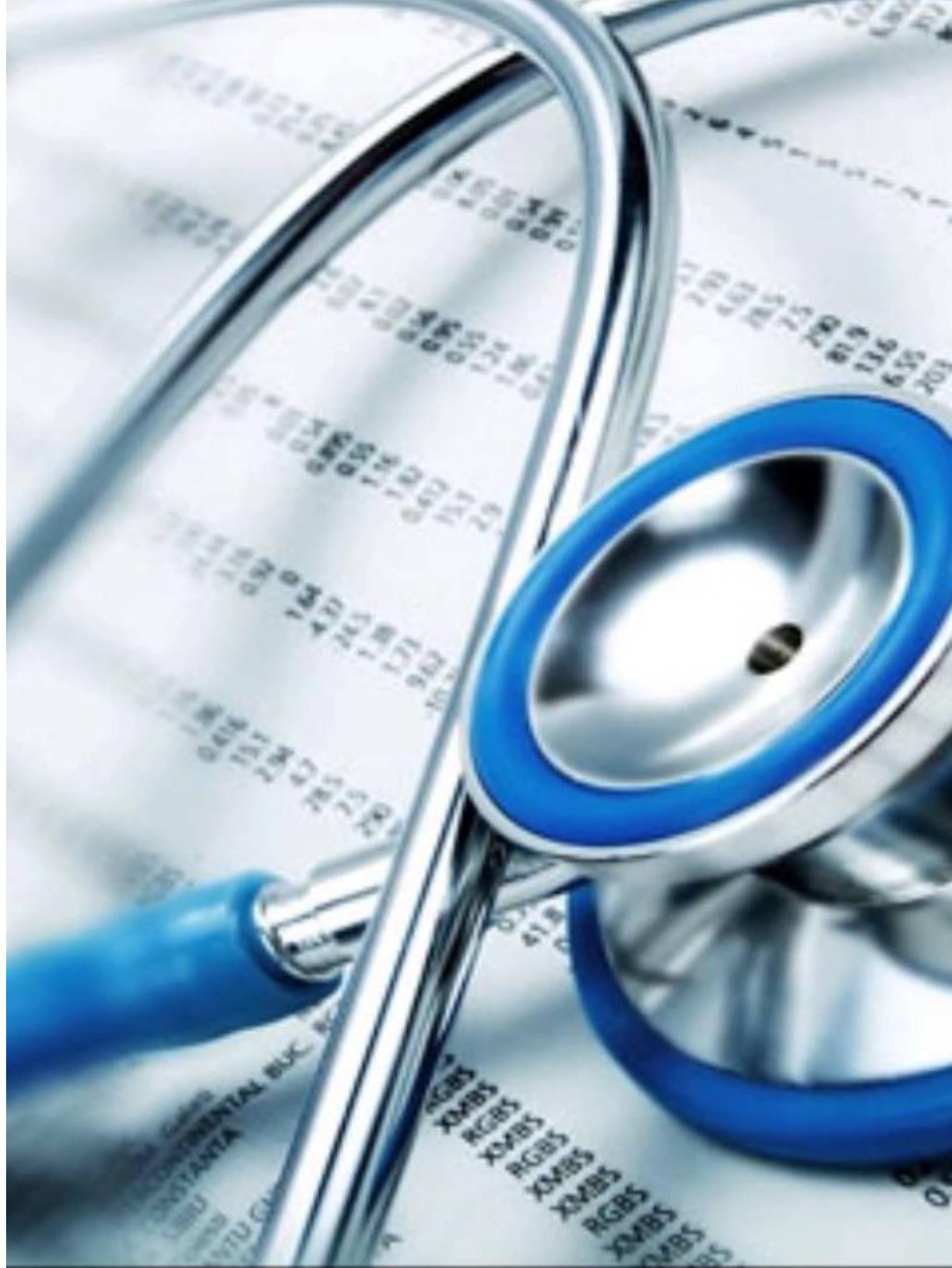
While some GP practices in England operate a formalised system of continuity of care, many do not. This investigation explores the safety risk associated with the lack of a system of continuity of care within GP practices

Published

Theme:
Primary care,
Delayed diagnosis

Investigation themes…

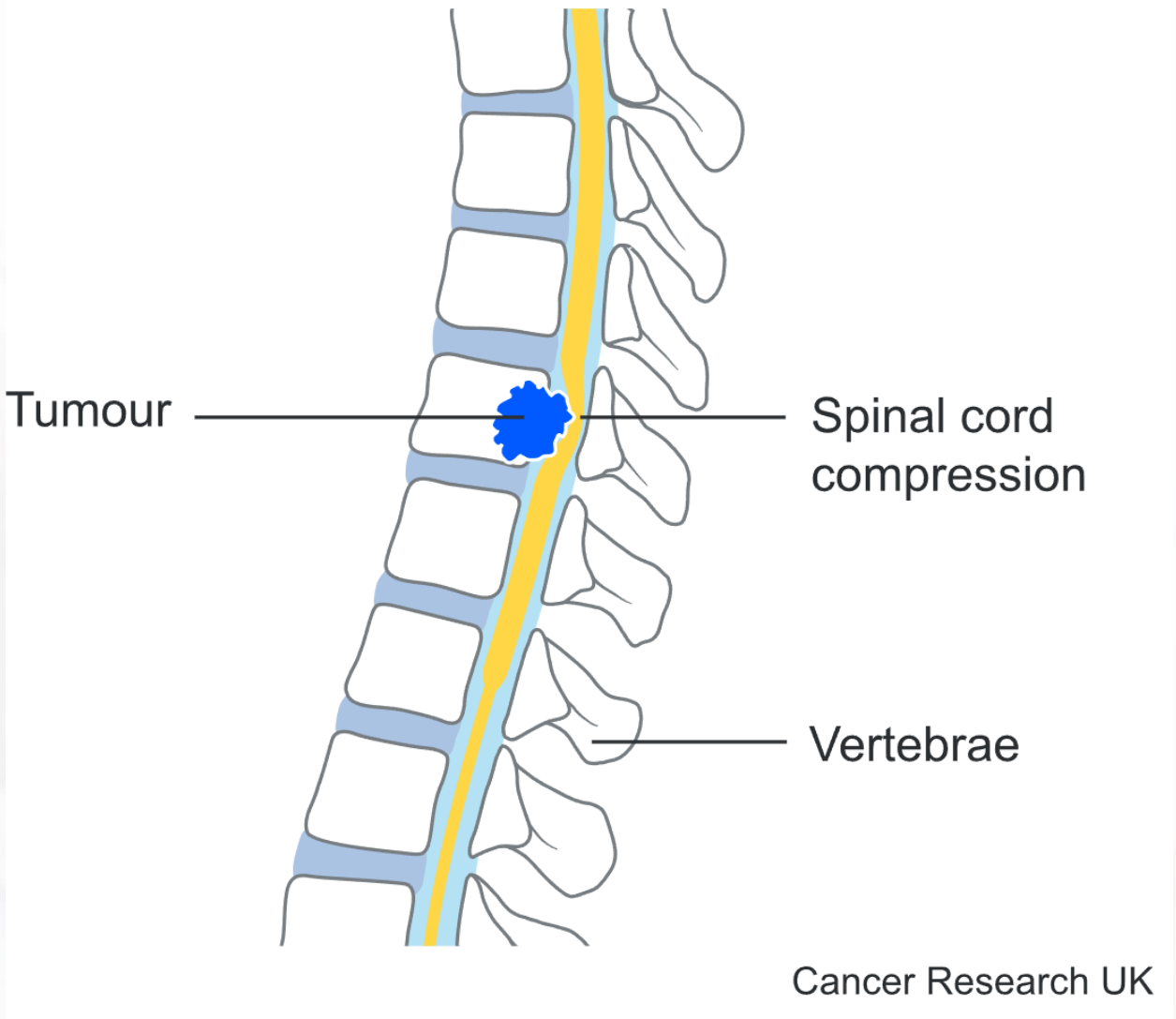
- Access to care
- Continuity of care
- Medication safety
- Interface and integration
- Interoperability
- Staff support
- Inclusive communication
- Safety management



Health Services Safety Investigations Body

Continuity of care: delayed diagnosis in GP practices

Publication: 30 November 2023
i005303



Brian had a history of breast cancer and had been discharged from the breast cancer service. Two years later he began to have back pain. Initially the pain was so severe that Brian visited his local emergency department (ED). He was discharged from the ED with pain relief and was advised to contact his GP practice.

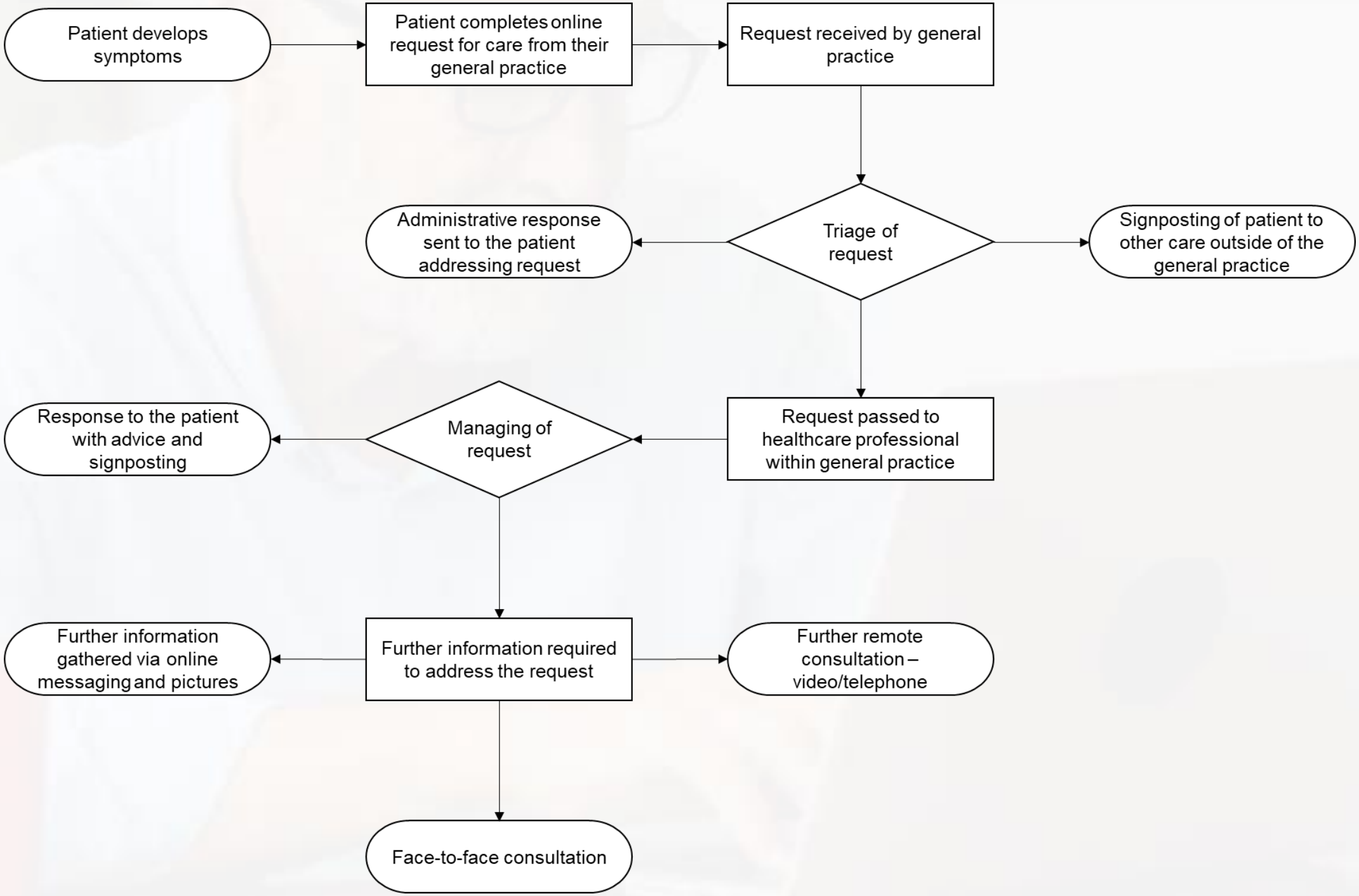
HSSIB recommends that NHS England updates the GP IT standards to ensure that patient continuity of care is maintained, including the identification and prioritisation (technically known as 'clear surfacing') of information to health and care professionals, when patients visit GP practices multiple times with unresolving symptoms.

GP practices can improve patient safety by aligning their staff wellbeing and patient safety policies to those of NHS England's proposed patient safety strategy.

Health Services Safety Investigations Body

Digital tools for online consultation in general practice

Publication: 25 July 2024
i026157


Patient develops symptoms
Patient completes online request for care from their general practice
Request received by general practice
Triage of request
Administrative response sent to the patient addressing request
Signposting of patient to other care outside of the general practice
Request passed to healthcare professional within general practice
Managing of request
Response to the patient with advice and signposting
Further information required to address the request
Further information gathered via online messaging and pictures
Further remote consultation – video/telephone
Face-to-face consultation

HSSIB recommends that NHS England undertakes an evaluation of the risks to patient safety of online consultation tools in general practice, taking into account the findings of this investigation, recent research, and the experiences of general practices. This is to identify and implement actions to support the safe delivery of care using online consultation tools in line with best practice.

HSSIB recommends that NHS England develops mechanisms for assuring that integrated care boards support general practices when implementing online consultation. This is to ensure online consultation tools are procured and implemented in ways that best support patient safety.


Reporting safety events
Software development
Safety observations
Creating the conditions
Long-term condition management


User involvement
Suggestions for ICBs
Alternatives for access
Project support

Our offer…

- Supporting improvements in patient safety
- Supporting improvements in conditions

- Listening with a ‘safe space’

- Education and development

We welcome any questions

Taking action to improve patient safety in primary care

Dr Kiren Collison

- Deputy Medical Director of Primary Care, NHS England

Dr Hester Wain

- Head of Patient Safety Policy, NHS England

Mark Smith

- National Patient Safety Partner (PSP), NHS England

Primary care patient safety strategy

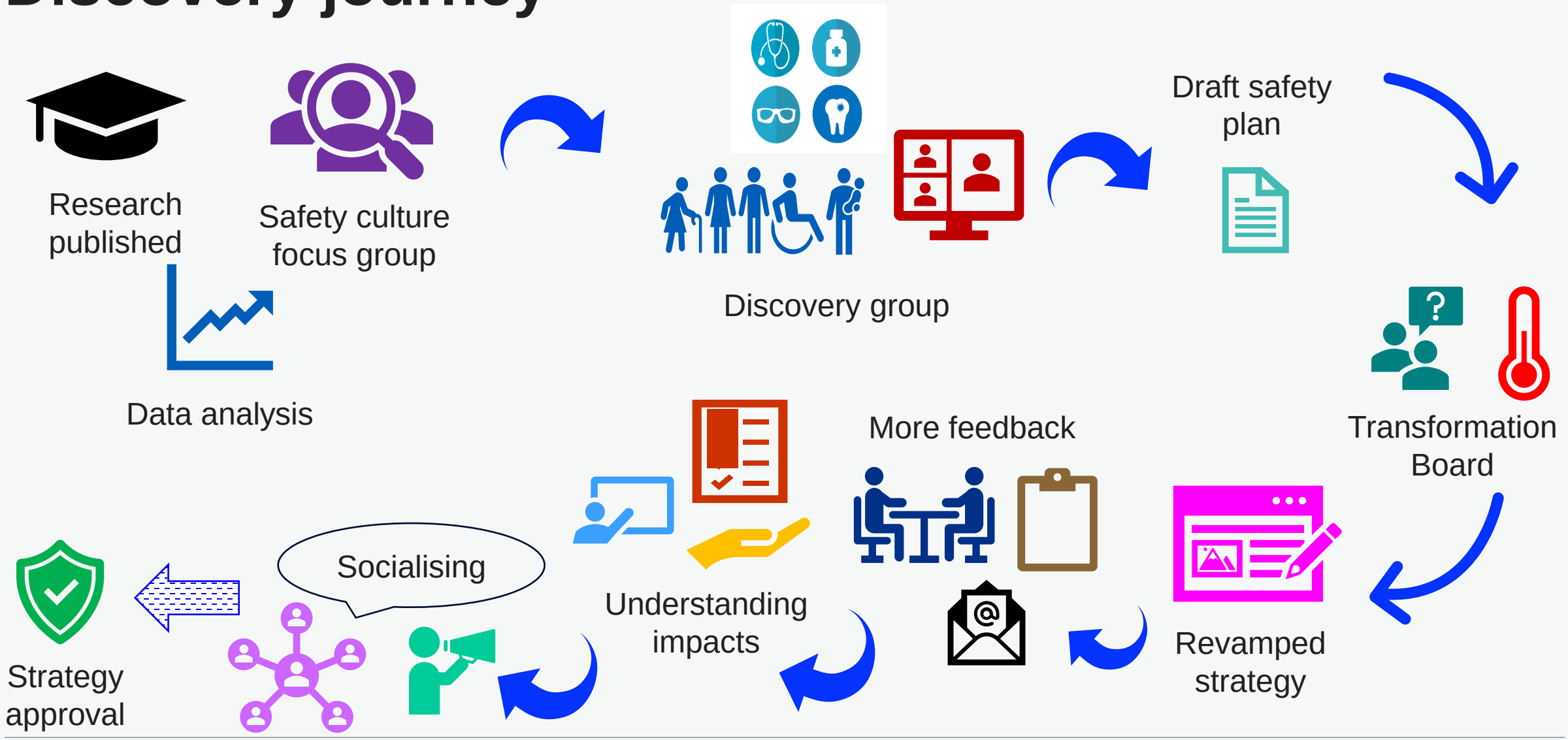
September 2024

Dr Kiren Collison (pronouns she/her)
GP, Deputy Medical Director for Primary care, NHSE

Hester Wain (she/her) PhD, #CallMe “Hes” or “Hester”
Head of Patient Safety Policy, NHSE hester.wain@nhs.net

Mark Smith, CSci CChem MRSC, National Patient Safety Partner

Discovery journey

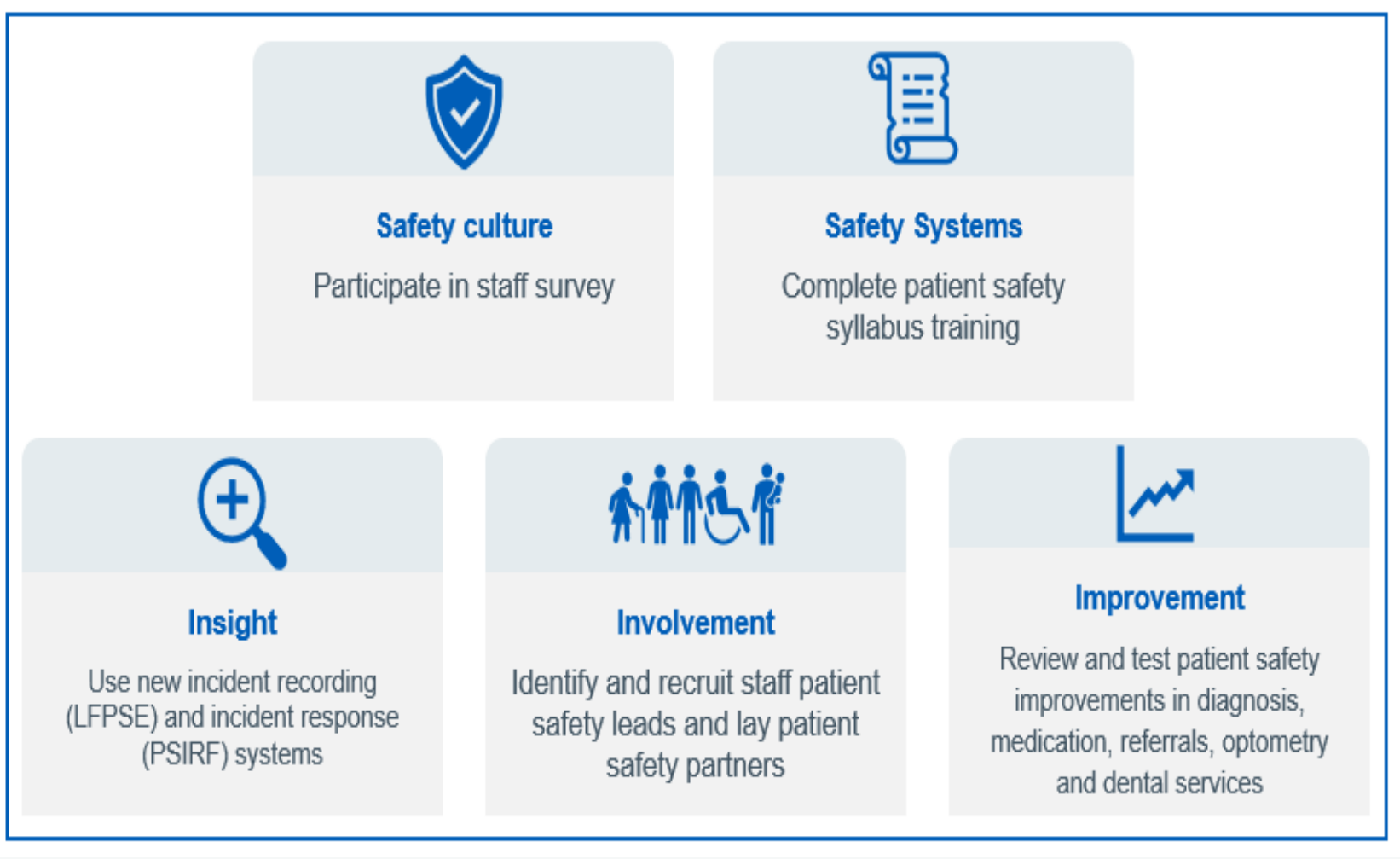


The impact of patient safety in primary care

- 90% of all NHS patient interactions occur in primary care
- 97% of encounters in general practice are safe
- Currently 0.7% of the 2.4 million patient safety incidents annually recorded nationally relate to primary care, so there is probably an under-representation of harm
- 21% of all new claims to NHS Resolution are from general practice (as reported in the new CNSGP and ELSP claims notified in 2023/24)
- Expenditure of £149 million for GP indemnity via NHS Resolution in 2023/34
- Avery et al., 2020 estimated there are between 19,800 and 32,200 incidents of avoidable significant harm in general practice in England per year (similar data for community pharmacy, optometry and dental services are unknown):
  - 61% diagnosis
  - 26% medication
  - 11% referrals
- Every incident of significant harm has a personal cost to patients, service users, families, carers and staff.
- Plus the financial cost of incident-related treatments, estimated at more than £100 million per year across the whole of primary care

Patient safety primary care strategy

1. Developing a supportive, learning environment and just culture in primary care, with sharing across the system so that the services can continually improve.
2. Ensuring that the safety and wellbeing of patients and staff is central, and that our approach to managing safety is systematic and based on safety science and systems thinking.
3. Involving patients in the identification and co-design of primary care patient safety ambitions, opportunities and improvements.



Primary care capacity

- Acknowledging the **huge pressures** in primary care
- Suggestions came from primary care staff, patients and local commissioners and therefore aim to address issues that have arisen locally
- Many of the actions are about the **process of enhancing safety**
- Aiming to keep bureaucracy to a minimum, such that recommendations utilise existing processes and structures for implementation ie ***instead of*** **rather than** ***more of***
- **National commitments** - focus on how the different parts of the ICB/system/region/national team can support primary care (ie it is not all directed at primary care frontline teams)
- **Timeframe** for local commitments is not specified and aims to be medium to long term with flexibility in response to system capacity and amount of transformation needed
- Implementation is about **what we can do well** and how we can deliver this effectively
- Aiming to **share the burden** across boundaries and between systems, changing mindsets and supporting improvements in the patient journey

Benefits

To patients and families:

- Fewer patients are harmed, which should lead to fewer complaints.
- Provision of free online patient safety training to lay patient representatives such as members of Patient participation groups (PPGs) will enable them to be more active participants in the patient safety agenda supporting their GP practices.
- Patients involved in co-designing their primary care services will be able to influence the inclusion of patient safety improvements that matter the most to them.
- Increased national recording of safety events, especially those which are new or unusual, will lead to improved patient safety alerts and solutions targeted directly at primary care patients.
- Patients and families will have reassurance that if after 3 consultations a patient's condition remains unresolved, or their symptoms are escalating and/or they have no substantiated diagnosis, their case should be elevated for review and a new assessment made: '3 strikes and we rethink'.

To staff:

- Free, online patient safety training (including primary care-specific modules) for all staff.
- Support from dedicated, trained patient safety staff within organisations and from ICBs (via Patient safety specialists).
- One national system (LFPSE) to record patient safety incidents, leading to familiarity of how to record and access information in different organisations. Plus, can be used for multiple purposes such as revalidation, annual appraisals, continual professional development (CPD), significant event audit/ analysis (SEA), quality improvement and audit evidence.
- Recording safety events is seen as a positive process by professional regulators demonstrating transparency, openness and reflection ie a positive patient safety culture.
- One system: Patient safety incident response framework (PSIRF) which is a learning tool to enable learning from patient safety incidents (linked to LFPSE). This leads to more opportunities for quality improvement within and between organisations and a move to an emphasis on systems. Piloting of PSIRF in general practice is underway via the South London Health Innovation Network.

Acknowledgements:
Primary care patient safety discovery group, PSIRF primary care group, National Patient safety partners, Project Sphere, Paul Foggitt

#CallMe
Because names matter

https://callmebecausenamesmatter.org/
https://kindnessinhealthcare.world/

Thank you

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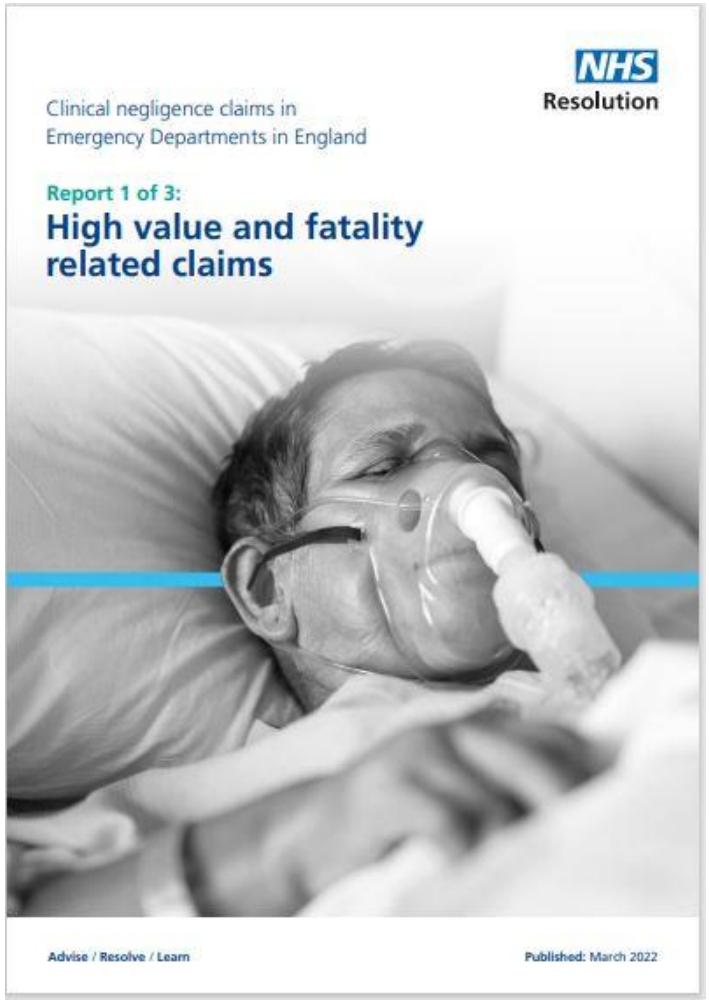
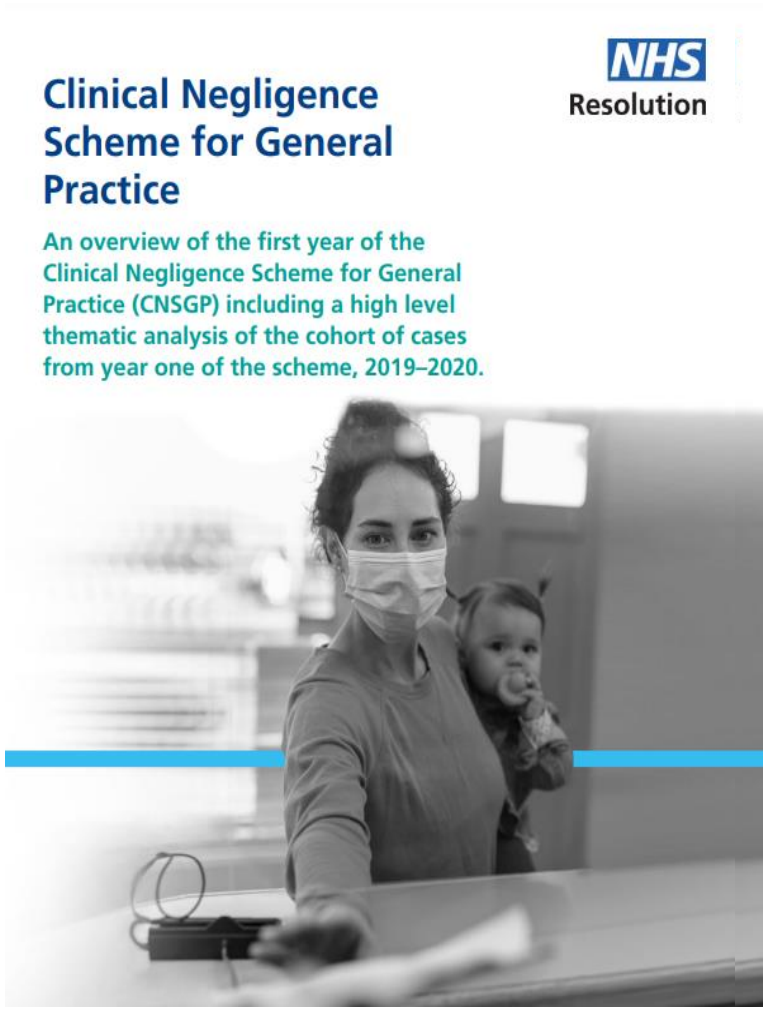
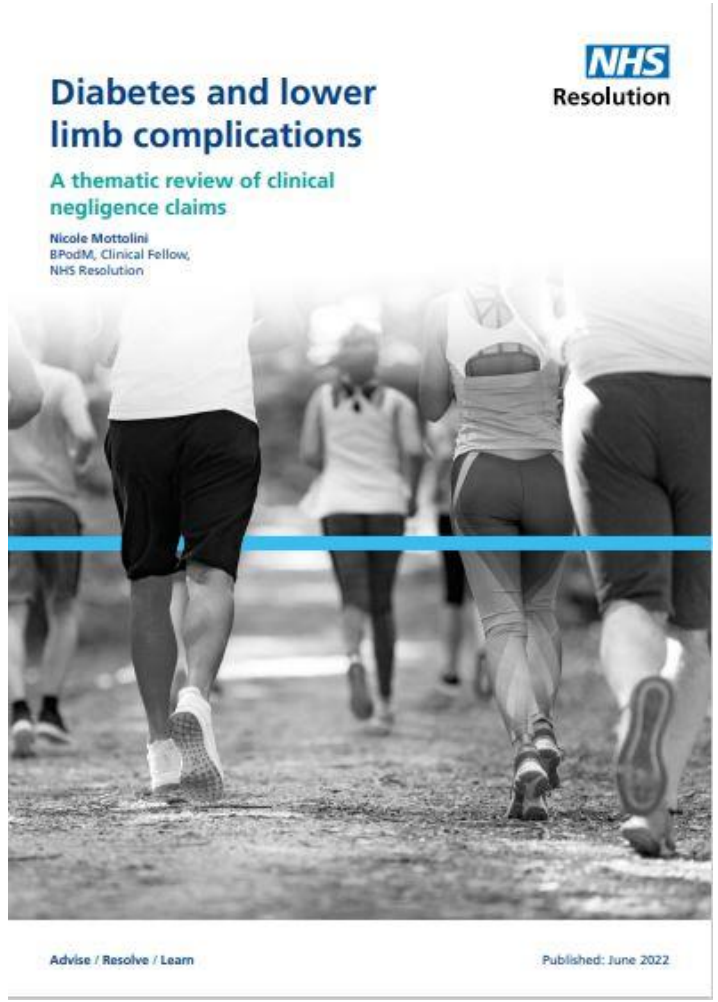
Taking action to improve patient safety in primary care – Q&A Panel

- **Samantha Thomas** - National Safety and Learning Lead for general practice | NHS Resolution
- **Andrew Murphy-Pittock** – Education Director | HSSIB
- **Dr Nick Woodier** – Senior Investigator | HSSIB
- **Dr Hester Wain** – Head of Patient Safety Policy | NHS England
- **Dr Kiren Collinson** – Deputy National Director of Primary Care | NHS England
- **Mark Smith** - National Patient Safety Partner | NHS England

Thematic reports







Resources

- NHS Resolution (2022) Clinical negligence scheme for general practice. An overview of the first year of the scheme https://resolution.nhs.uk/resources/nhs-resolution-first-year-of-an-indemnity-scheme-for-general-practice-published/

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Thank you