


National Patient Safety Agency

Can healthcare ever be as safe as aviation?
Reflections from the National Patient Safety Agency in England and Wales

Lord Naren Patel
Chair
National Patient Safety Agency

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The National Health Service



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The NHS Structure

- Government Body - Department of Health
- Funding – around 9% of GDP (£92billion)
- Separate approaches in England, Wales, Scotland and Northern Ireland
- Regional approach in England – 10 Strategic Health Authorities
- Hospitals and healthcare providers are referred to as ‘Trusts’ and they comprise of
 - Acute, Mental Health, Learning Disabilities, Ambulance & Primary Care Trusts
- Healthcare Commissioners
 - Commissioning Primary Care Trusts, General Practitioners

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NHS facts and figures

- A day in the life of the NHS, each day....
- **1.5 million** patients seen by 1.3 million staff
- **1.9 million** prescriptions issued
- **50,000** A& E attendances
- **28,000** sight tests
- **124,000** outpatient consultations
- **836,000** general practitioner consultations

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The Patient Safety Story

- *An Organisation with a Memory 2000*
 - highlighted failure of NHS to learn particularly when things went wrong, unlike other high risk industries
- *National Patient Safety Agency 2001*
 - set up to provide leadership and focus efforts to improve patient safety in the NHS by learning from patient safety incidents
 - Major focus on establishing a national patient safety reporting system – the National Reporting and Learning System

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Roles and Responsibilities of NPSA


- collect and analyse information through a national reporting and learning system
- assimilate other safety-related information from a variety of existing reporting systems
- learn lessons and produce solutions

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The National Reporting and Learning System


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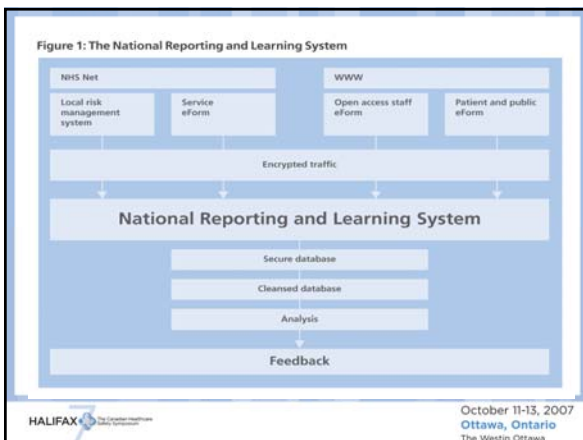


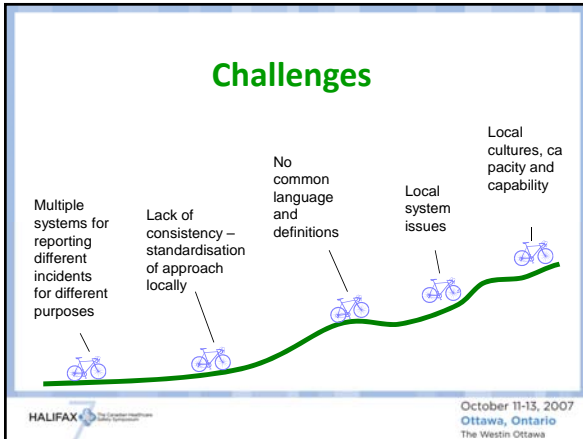
National Reporting and Learning System

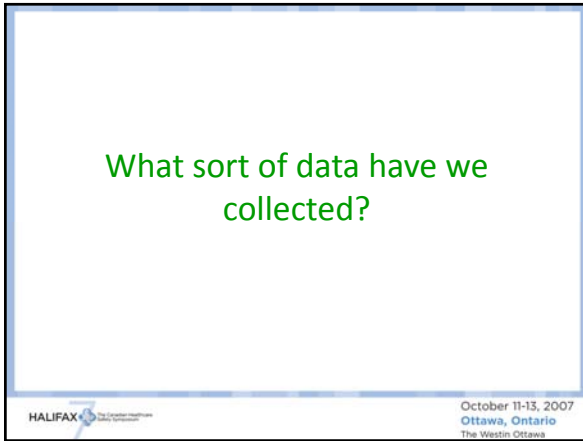
- National system which collects all staff reports of safety incidents in England and Wales
- Voluntary and confidential
- All 607 NHS organisations in England and Wales are connected through local risk management systems
- Mapped the national dataset to local datasets to meet both local and national needs for analysis

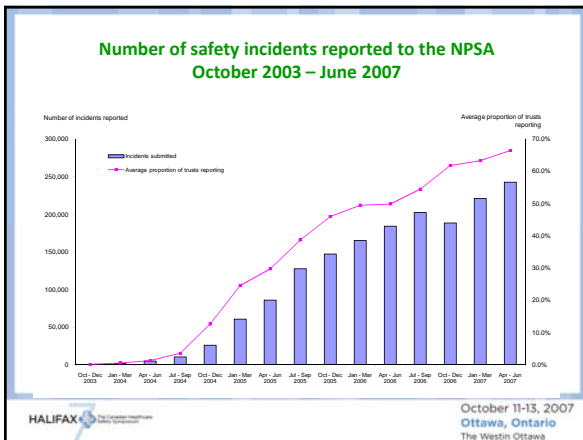
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Reporting in Numbers

21,985
The number of incidents which are likely to be categorised by reporters as severe or death (based on 1.3%)

104
The average number of days for a serious incident to be reported through to the NRLS

12,360
Highest number of reports from one Acute Trust (Oct 06-March 07)

1,773
Average number of reports from Acute Trusts (Oct 06-March 2007)

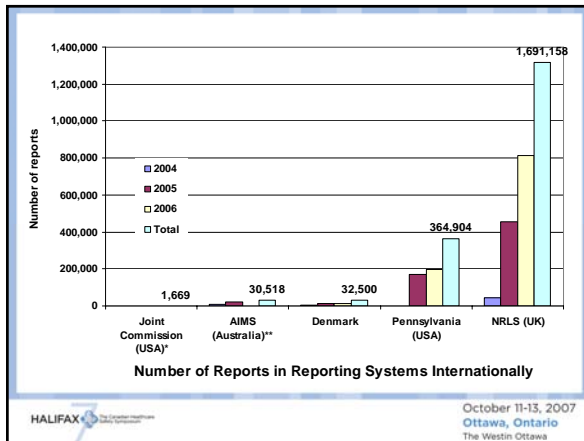
274
Average number of reports from PCOs (Oct 06-March 2007)

1,691,158
Total number of incidents reported to the NRLS since November 2003

Where do reports come from?

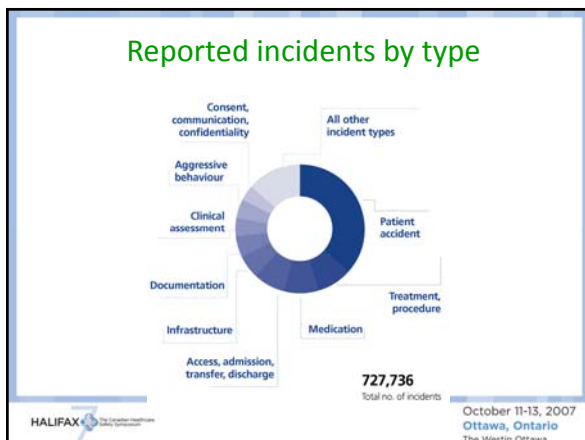
Category	Percentage
Acute Sector	72%
Mental Health	14%
Other	14%

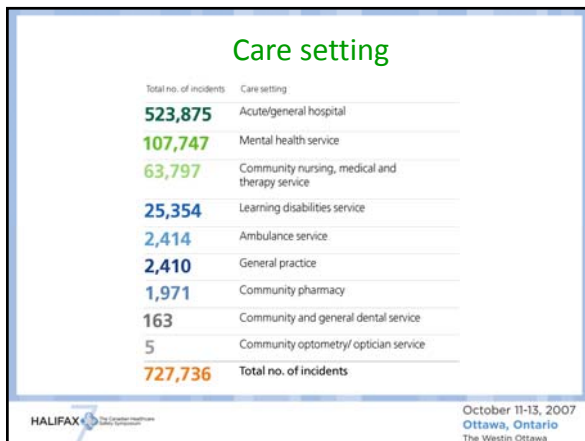
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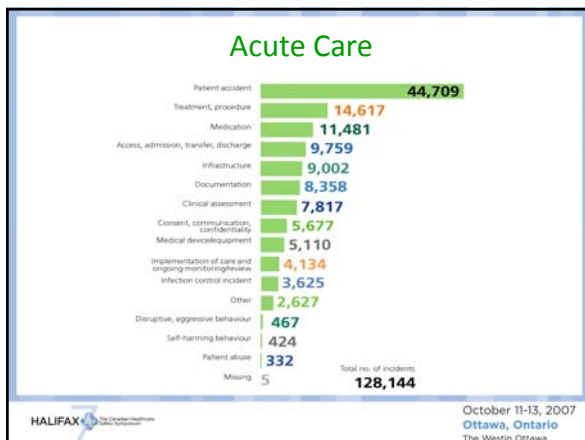


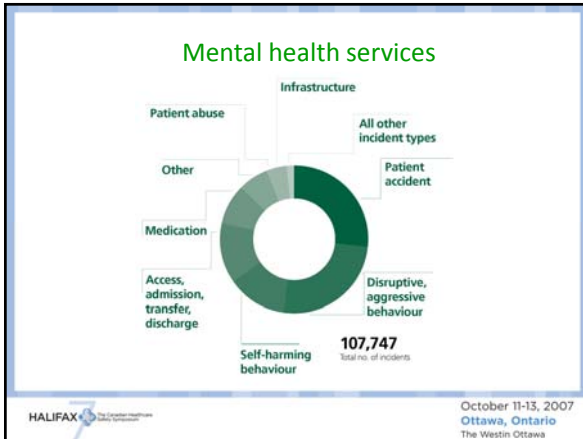
Let me take you through the most recent data analysis....
April 2006
to March 2007

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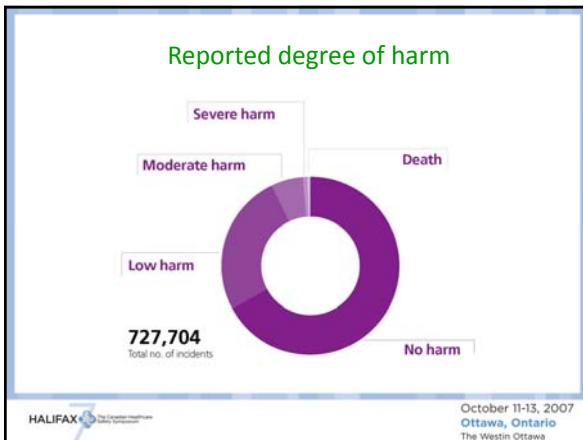





General practice

Total no. incidents	Incident type
607	Medication
310	Consent, communication, confidentiality
296	Access, admission, transfer, discharge
293	Documentation
229	Clinical assessment
168	Treatment, procedure
140	Patient accident
111	Infrastructure
87	Implementation of care and ongoing monitoring/review
54	Medical advisor/equipment
47	Other
29	Disruptive, aggressive behaviour
14	Self-harming behaviour
14	Infection control incident
11	Patient abuse
2,410	Total number of incidents

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So what have we done with all these data?

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Medicines Safety



- 60,000 medication incidents reported via the NRLS between January 2005 – June 2007

Key messages:

- Improve staff skills and competencies
- Ensure medicines are not omitted
- Minimise dosing errors
- Correct medicines - correct patients
- Document allergy status

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Medication Safety Solutions

- Promoting safer measurement and administration of liquid medicines via oral and other enteral routes
 - Per year, 66 patient safety incidents - 6 leading to deaths
- Promoting safer use of injectable medicines
 - Per year, 800 patient safety incidents per month – 25 leading to death and 28 to serious harm
- Safer use of anticoagulants
 - Per year, 1,250 patient safety incident reports - 12 leading to death

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The reporting system has led to...

- Improving the safety of deteriorating patients
- Improving the safety of delivering blood products
- Reducing the risks associated with nasogastric tube insertion
- Re-designing ambulances to reduce risk and harm

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How good has it been?

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Lessons

1. We have a huge amount of valuable data for data mining and hypothesis generation
2. Well established system of safety alerts
3. Huge variability in reporting – across organisations/sectors and professions
4. Significant issues with accuracy and completeness of data

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Are we making a difference

- Connected all NHS organisations
- Changing and improving the culture of reporting – in particular in acute care
- Provides us with data to view across all care settings at a national level
- Ability to influence the national agenda

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Safety Culture

- Research suggests that high reporting is associated with a strong safety culture

– Ref: Hutchinson et al – research from the NHS staff survey

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Do we need a National Reporting and Learning System?

Yes

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Controversies in Healthcare Safety

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