Safer Systems for a Safer NHS

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It’s the first thing you learn!

*Primum non nocere* is a Latin phrase that means "First, do no harm." The phrase is sometimes recorded as *primum nil nocere*. It is one of the principal precepts all medical students are taught in medical school. It reminds a physician that he or she must consider the possible harm that any intervention might do. It is most often mentioned when debating use of an intervention with an obvious chance of harm but a less certain chance of benefit. Since at least 1860, the phrase has been a hallowed expression for physicians of hope, intention, humility, and recognition that human acts with good intentions may have unwanted consequences.
I swear by Apollo, Asclepius, Hygieia, and Panacea, and I take to witness all the gods, all the goddesses, to keep according to my ability and my judgment, the following Oath.

To consider dear to me as my parents him who taught me this art; to live in common with him and if necessary to share my goods with him; To look upon his children as my own brothers, to teach them this art if they so desire without fee or written promise; to impart to my sons and the sons of the master who taught me and the disciples who have enrolled themselves and have agreed to the rules of the profession, but to these alone the precepts and the instruction.

I will prescribe regimens for the good of my patients according to my ability and my judgment and never do harm to anyone.
...and then forget.

IN THE UK:

10% admissions caused by medication or procedural errors.

Annual cost £466m

(BMJ April 2004)
everywhere!

In the US:

50 – 100k deaths from medication annually

(“To err is human….“ IOM 2000“)
Improving Patient Safety-1
Do we have a problem with Patient Safety in Europe?:

- Yes: 78%
- No: 2%
- I am not sure: 20%
Improving Patient Safety

Has your hospital implemented a medical error reduction or other patient safety programme?:

[Bar chart showing responses: 43% Yes, 18% No, 39% I am not sure]
Improving Patient Safety -1.  
Has your hospital implemented an IT system to improve patient safety?:

- Yes: 33% 
- No: 36% 
- I am not sure: 31%
Improving Patient Safety – 2.
Do you agree that all relevant stakeholders should work together to make patient safety a top priority in Europe?:

- Yes: 91%
- No: 9%
- I am not sure: 0%
Why is safety a peripheral and emerging issue, when it's always mentioned in the first sentence by the great and good?
UK wakes up!

2000 AD. “An organisation with a memory”
UK CMO

2001 AD. National Patient Safety Agency formed “to enable organisations to capture and report safety incidents, and to learn from them”.
……but it still didn’t work!

2006 AD. Review of NPSA.
“Why isn’t it making a difference yet……?”
NPSA Report into Connecting for Health

- National Programme for IT formed in 2002
- Commissioned 2004 by Deputy Chief Medical Officer (DCMO)
- Conducted by NPSA Risk Advisor
Report Findings

Not identifying safety as a benefit to drive the programme.

No formal risk assessment.

No formal safety management system.

Reliance on clinicians to instinctively address patient safety problems.
Report Conclusion

“NPfIT not addressing safety in structured, proactive manner as other safety critical industries would.”
Action Taken

Appointment of National Clinical Safety Officer (seconded from NPSA)

Implementation of Clinical Safety Management System (CSMS)

Adoption of principles of IEC 61508
  • Patient Safety Assessment
  • Safety Case
  • Safety Closure Report

Accredited clinician training

Governance Structure
  • Clinical Safety Group (fortnightly)
  • Clinical Risk and Safety Meeting (monthly)
  • Clinical Risk and Safety Board (quarterly)
On-going work

Safer IT products.

Clinical Risk Reduction.

Safer Implementation.
Safer IT Products

Clinical risk management system administered through Clinical Safety Group

Required documentation
Certificate of Authority to Release (CATR)
Safety incident management process
Clinical Risk Reduction

Right patient right care (safe management of blood products; NHS number, wristband dataset)
Safer prescribing (alerts; ‘top 10’ unsafe drugs)
Safer handover (scoping; dataset development)
Safer implementation

High-level strategy
Safe implementation toolkit
Proposal for safe implementation network
Second NPSA Report 2006

Major findings

• pro-active actions and progress made by NHS CFH to put in place systems and processes to address patient safety in the NPfIT in an explicit, proactive, structured and robust manner

• Gaps (opportunities for further improvement) where further development will enhance the effectiveness and efficiency of the NPfIT helping the NHS realise patient safety benefits

• Recommendations for NHS CFH’s consideration, aimed at realising the opportunities for improvement identified.
Conclusion

Considerable movement from ‘standing start’ 2 years ago.

Major workstreams underway.

Still early days.

Nevertheless, this is pioneering work on safety in Health IT.
Recent Developments

Appointment of Chief Clinical Officer

Development of new Health IT Standard

Development of patient safety policy

Description of safety management approach

Refinement of safety incident management process and procedure
Recent NHS initiative

Imperial College, St Mary’s hospital, and the Hammersmith hospital.
£4.5m for patient safety and service quality.
On the back of the Cooksey reform of research funding.
A Charter for the safety of patients

We, the undersigned, have separate but linked responsibilities for key aspects of the provision of healthcare and recognise that:

- We must offer the leadership which will accelerate change. It will call for close cooperation, energy, passion and clear direction.
- A culture of commitment to safe care must be fostered and embraced by all those involved in providing care so that protecting patients from avoidable harm becomes an accepted feature of 'the way things are done around here'.
- Safety is at the core of clinical practice and patient care: we all have a role to play in ensuring that the safety of care is continuously improved.
- We need to revitalise our approaches for improving the safety of care, to eliminate suffering, avoidable harm and care of poor quality.

Accordingly, we make this public commitment fresh, that our organisations will:

- Encourage renewed engagement, contributions and challenge from professionals, from other health service staff and organisations, and from patients and the public to support us in fulfilling these commitments.
- Ensure that the safety of patients is a key priority in our work - in practice, as well as words.
- Work closely together on programmes and initiatives to contribute to improvements in the safety of care that will benefit patients.
- Exchange information, data and intelligence actively when it is appropriate to do so in the interests of the safety of patients.
- Be responsible for providing lessons from adverse events when things go wrong, and "near misses", so that lessons may be learned.

We lead the creation of a culture and environment which promotes individual, organisational, and system improvement and learning, to prevent harm.

________________________
[Signatures of individuals]
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Some questions.

How many mistakes are made by patients?

How far will a “no blame” culture take us?
Embedding safety into aviation culture took 10 – 15 years!
Patient sees doctor in 3200 BC

The iceman carried a series of tattoos to inform any “doctor” of his medical problems AND to identify relevant acupuncture treatment sites.

The HRCT scan of the iceman missed the arrow head