

CLINICAL GOVERNANCE

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Editorial: Patient and public involvement

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The aim of the NHS quality agenda is to rebuild the confidence of patients and the public, in part by giving them a greater say in their care and their local health services. The Commission for Health Improvement (CHI), in its clinical governance reviews, examines the progress of NHS organisations with patient and public involvement; in particular, it looks at how patients and carers are involved in planning services and what their experience tells us about the quality of care they have received. CHI has now taken over the National Patient Survey Programme and published guidance on the acute and specialist trust surveys that will need to be carried out by individual organisations, and the results will be used as performance indicators and for star ratings.

Patient satisfaction consists of both a cognitive evaluation and an emotional reaction to the care received and the services delivered. An individual subjective perception is thus closely tied to expectations. For this reason there is a growing consensus that asking patients what they experienced is more informative than simply asking whether they were satisfied. However, a review of published studies suggests that few use methods that are both valid and reliable¹. This lack of measurement

standardisation and patient satisfaction instrument rigour has resulted in an inability to benchmark both locally and nationally. A comprehensive review² of patient satisfaction, which assessed the strengths and weaknesses of both quantitative and qualitative methods and assessed some commercially available options, confirms the need to show both quality outcomes and consumer satisfaction with services. Hospitals and health-care systems that invest in programmes to determine how patients evaluate their experiences are likely to find valuable information with which they can make improvements in care delivery and to services.

Only time will tell whether the results of national patient surveys will provide the information necessary to generate service improvement as well as a means to benchmark organisations and contribute to the assessment of performance.

This issue includes the lessons learnt in the implementation of national patient surveys as well as public involvement in clinical governance; a number of websites dealing with this issue are given in the 'WhoWhatWhere?' column.

Please continue to send in your practical contributions so that your learning can be disseminated to the wider NHS.

References

- 1 Sitzia J. How valid and reliable are patient satisfaction data? An analysis of 195 studies. *International Journal of Quality in Health Care* 1999;11:319–28
- 2 Urden LD. Patient satisfaction measurement: current issues and implications. *Outcomes Management* 2002;6:125–31

Readership questionnaire

Please take the time to complete the questionnaire on the back of the separate address sheet, and let us know your views.

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Public involvement in clinical governance

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- There is a difference in the perceptions of professionals and the public regarding how the latter could and should be involved in clinical governance.
- 'Patient' and 'public' culture will need to meet, to enable successful implementation of the policy of public involvement.
- Primary care trusts must seek to influence this cultural shift.
- Strategic leaders should reconsider what constitutes a 'public viewpoint'.

The NHS is seeking to improve public confidence in its services by increasing transparency and accountability. Primary care trusts (PCTs) are expected to involve the public in commissioning and service delivery, to make health-care more responsive to local needs and priorities. In particular, PCTs are required to involve the public in implementing clinical governance in primary care, for which they have recently acquired responsibility. This approach assumes that both primary health-care professionals and lay people in general support this public role. Our research sought to explore lay and professional perceptions of public involvement in clinical governance.

Methods

We adopted a qualitative methodology. We invited all 65 board members of a primary care group (PCG) that spans a large northern

conurbation to participate in in-depth interviews and 32 (49%) agreed to do so. The sample included GPs, nurses, social service staff and lay members. We also conducted 10 focus groups with a total of 60 lay informants: three focus groups were with 'citizens' (sampled from wards with a wide range of deprivation scores); three were with local health interest groups; two were with patient forums; and two were with frequent service users. AL and KC conducted the interviews and focus groups, and analysed the transcribed data drawing upon the technique of 'constant comparison'.

How clinical governance is understood

Clinical governance was perceived by board members to be synonymous with the delivery, maintenance and measurement of quality. Almost all the PCG board members interviewed made this association, despite acknowledging the difficulties in defining the term 'quality'. They thought a key impetus for clinical governance was the series of adverse incidents (e.g. those involving Alder Hey Hospital, Harold Shipman and heart surgery in Bristol) that intensified the requirement to address public confidence and the need to incorporate professional accountability within health service management.

Only one of the lay informants was aware of the term 'clinical governance'. They were more familiar with concepts of quality of care, focused in particular on access to GPs and GPs' communication skills.

Public involvement in clinical governance

One strategy to address issues of quality, accountability and public confidence is public involvement in clinical governance. Board members expressed mixed views about how effectively clinical governance could rebuild public confidence. Significantly, they considered that culture

change, resources and training were required to implement clinical governance successfully. Although culture change was described as necessary for GPs in particular, it was also thought to be essential for patients; one nurse interviewed stated that 'it's not just our culture shift, it's their culture shift as well'. This highlights a key challenge for effective public involvement.

The Department of Health¹ has set out three key components of clinical governance; we therefore analysed how the study participants viewed public involvement in these specific respects.

(1) Dealing with poor performance

With regard to their experiences of poor performance, board members were of the view that, in the words of one nurse, 'it's better if patients do complain, en masse'. However, they did not support public involvement in the process of managing cases of poor performance. Although lay informants also did not support direct public involvement in performance procedures, they saw a clear and essential role for a lay overseer to ensure that PCTs dealt effectively with poor performance.

(2) Quality assessment and improvement

Professionals thought that while the public would be interested in performance indicators, the challenge was to find the right indicators. Lay informants wanted access to reports about the quality of health-care provided, as they were 'the ones who are likely to experience it'. In particular, negative information helped them to make informed choices. For instance, a resident of a middle-income ward explained that if a doctor was in some way at fault, 'You certainly wouldn't go to that doctor again, would you?'

(3) Professional development and sharing ideas

Professionals saw a clear role for patients in educating health-care workers. Lay informants felt that the

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continuing professional education of health-care providers was essential and that patients with particular health problems could usefully inform this aspect of clinical governance. A member of a spina bifida special interest group commented, 'I think there needs to be a rolling programme for training which is delivered to health professionals'.

Who should be involved?

There was little support from either lay or professional informants for the concept of 'public' involvement. Lay informants suggested that considerable personal commitment was required for public involvement in clinical governance, and that lay people sufficiently enthused were likely to be motivated by personal (sometimes negative) experiences of health-care. However, while health-care users wanted input through lay 'overseers', professionals conceptualised public involvement in terms of how existing 'patients' could be involved; they favoured input primarily via patient forums, a model that has traditionally been used in general practice. Professionals were

concerned that the views of patients with personal agendas would compete with 'public' views and result in a lack of representation of wider opinions.

Conclusions

Our research suggests that lay people and professionals are approaching public involvement from different conceptual starting points. Lay people perceive their involvement in consumerist terms: 'How can I personally get the best quality of health-care?' Professionals seek a democratic or citizenship viewpoint: 'How can we get a representative patient viewpoint?' We found that some lay board members did not consider themselves to be community representatives, but to be there to challenge the status quo and oversee activities. While lay and professional conceptual positions are in conflict, public involvement may be marginalised, undervalued and less effective than could otherwise be the case.

Overall, there is recognition that the medical profession has been 'closed' and that doctors must now

review and modify their attitudes and practices. However, 'patient' and 'public' culture will also have to shift, to enable the successful implementation of the policy of public involvement in clinical governance. It will require those involved to engage with service providers in ways that combine their personal concerns as health-care consumers with a community perspective.

Primary care trusts should not develop strategies for public involvement in isolation. They must seek to influence cultural shifts. There is a need to reconsider who the 'public' are and what constitutes a 'public' viewpoint. Without such an approach, and the resources to support it, effective public involvement in clinical governance is unsustainable.

Acknowledgement

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Reference

- 1 Department of Health. *The New NHS: Modern, Dependable*. London: HMSO, 1997

National surveys: doing one in-house

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- The government is undertaking a wide-reaching programme of national surveys to contribute to its assessment of NHS performance.
- It can be expensive to contract with an external organisation for such a survey.
- Existing trust information technology and clinical governance systems can be used to conduct national surveys in-house.

Over the past year, there has been a drive to obtain feedback from patients about their experiences of care in the NHS. In order to accomplish this task, the NHS has launched the National Patient Survey Programme. This will attempt

to gather information from those who use the services of acute, primary care, mental health and ambulance trusts, among others. A survey of NHS staff is also planned, as are additional surveys that will cover the National Service Frameworks.

A dedicated advice centre has been established along with a website (www.nhssurveys.org) that will help NHS trusts to undertake this mandatory programme. Detailed instructions for different types of survey are available on the website for those wishing to carry out the task in-house. These give the randomisation strategy, cut-off points and the specific client groups that are required. They also cover the response

rate and time frame for reminder letters and follow-up mail shots.

The surveys are being overseen by the Commission for Health Improvement (CHI) and the results are likely to contribute to a trust's overall performance rating under the star system.

No money has accompanied this exercise, but some NHS trusts may be obliged to undertake two or even three surveys over an as yet undefined time period. Trusts are left with the option of conducting a survey in-house or contracting an external organisation to carry it out on their behalf. Information from the website suggests that three surveys could cost around £30,000 using the most expensive contractor and

around £12,000–£15,000 using the least expensive.

In 2003, some NHS trusts were provided with an opportunity to conduct a full-scale survey of users of mental health services on a voluntary basis. In Sheffield we decided to undertake the NHS Mental Health Users Survey (MHUS) entirely in-house. We report the details of this exercise, together with costings based on staff time and equipment. We hope it will be of use to some other trusts that are making a decision regarding the best and most economically sound approach to this task¹⁻³.

Making a start: research or evaluation?

In Sheffield, considerable debate was engendered around the issue of whether or not these nationally directed surveys should be defined as audit/evaluation or research activity. This definition is important, because different parameters – and hence costs – determine how a particular activity is undertaken under the umbrella of research governance or of clinical governance. The situation was further complicated because, in the case of the MHUS, the instrument and methodology had been sent to a multi-centre research ethics committee (MREC) for approval.

Direct enquiry to the Department of Health and the CHI elicited differing responses and some clarity on this issue is expected before the mandatory MHUS is conducted in 2004. In the meantime, the first step that needs to be taken is for trusts to decide whether surveys of this type are carried out under clinical or research governance.

Across the UK, different systems are in place to manage research governance, and some trusts may not have the necessary infrastructure to accommodate research activity at all. Trusts need to be aware of time constraints attached to CHI-directed surveys and determine whether their research management processes could be sufficiently timely. However, it is hoped that such surveys could be fast-tracked through any local systems that are in place.

In our case, carrying out the survey under research governance would have raised the possibility of having to find a ‘lead’ for the project. In addition, it could be argued that costs attached to the survey should

be met through the research and development budget rather than directorate budgets attached to the trust. After much debate, it was decided to pursue the survey under clinical rather than research governance, although, clearly, this situation may have to change, pending further advice from the CHI and the Department of Health. Trusts should, however, notify their local research ethics committee of any national MREC-approved surveys they are undertaking.

Lesson learned

- In the absence of clear guidance from either the CHI or the Department of Health, discuss with your local research manager and clinical governance lead the most practical route under which these surveys are to be conducted.

Getting a team together

The most obvious staff to carry out these surveys are the personnel of an established clinical audit or clinical effectiveness department, with a clinical governance lead. In addition, the involvement of local information technology (IT) staff is, in our view, a prerequisite. The composition of the Sheffield team is shown in Table 1. There is also involvement of the trust’s postal staff, who need to be kept up to date on the potential arrival and distribution of several hundred items.

This looks like a substantial number of staff. However, while the total amount of time spent on the survey varied considerably it did not exceed seven days over a three-month period for any single member of the team.

An important element of this group is the service user representatives, who should be consulted from the start. In particular, local

service users should see the survey before it is distributed and comment on any items that could cause upset or offence. This is particularly important for the MHUS. In practice, we had few problems since the survey organisers had already consulted several user groups during the survey development.

Once established, we found that four meetings of this team were adequate to set time scales and allocate tasks.

Lessons learned

- Ensure adequate consultation with service user representatives.
- Get commitment from the IT department to coordinate the local audit system and patient administration system (PAS).

In-house system requirements

In Sheffield, we are fortunate in having both data-scanning software and a client-server-based PAS. However, we do not consider these assets exceptional in a modern NHS trust (many acute trusts use data-scanning software, particularly for clinical audit activity).

In addition to established systems, other details have to be arranged. An adequate number of envelopes need to be purchased. If data scanning is to be used, the size of envelope (C4, i.e. large enough to hold an A4 sheet unfolded) is important, as the process can be problematic if the returned questionnaire is folded.

Freepost licences need to be obtained. When applying for these, be prepared for some bizarre requests from the Post Office for identification purposes (we were asked to provide a recent gas bill!). Two licences are required: the first is to enable the recipient to return the questionnaire free of charge and the

Table 1. Composition of the in-house user survey team in Sheffield

Category	Number of team members
Service user representative	1
Data input personnel	1
Clinical audit facilitator	2
Specialist information technology support staff	1
Departmental personal assistant	2
Executive director	1
Director of clinical governance	1
Manager of the adult mental health Care Programme Approach	1
Project manager	1

second allows for the return to the trust of undeliverable envelopes.

A 'free-phone' helpline also needs to be established, with designated team members available to take queries during working hours. (We actually received few such telephone calls.)

Lessons learned

- Allow adequate time (two to three weeks) to obtain Post Office licences.
- Ensure your trust has adequate telephone lines to set up 'free-phone' numbers.

The questionnaire

The questionnaire plus covering and reminder letters can be downloaded from the survey website. In the case of the MHUS, the survey and methodology had already been sent to an MREC. MRECs give their approval on the basis of the material provided to them. This means you cannot alter either the survey or covering letters in any way without violating the terms of the MREC approval. It is necessary, though, to include individual trust details and some way of identifying who has returned the survey, to avoid reminder letters or further surveys being mailed to people who have already returned them.

In our case, we used a bold pre-printed numerical identifier on the first page of the survey. A local printing service therefore needs to be engaged to print adequate numbers of the questionnaire, with identifiers pre-printed incrementally. Generally, these services will also provide envelopes, print Freepost addresses and staple multiple sheets.

The identification number was matched electronically with the patient number on the trust's PAS. Since in Sheffield the PAS contains patients' demographic details, it was possible to use the PAS to print address labels, define the client group and, using the unique identifier, track clients who had received surveys in the first mail shot and returned them. This avoided repeat mailings to clients who had returned questionnaires in the first round.

The client list generated by the PAS was retained within the system as a separate table and was covered by the Data Protection Act and confidentiality policies. Before a final one is assembled, the list of clients

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selected to receive a survey should be sent to the NHS National Strategic Tracing Service to ensure, as far as possible, that surveys are not sent to deceased persons.

Lesson learned

- Engage a good local printing firm. (Universities frequently have sophisticated printing facilities but are not always the cheapest.)

Processing

Once returned, questionnaires were logged on a spreadsheet, together with their unique identifier. This spreadsheet was then returned to the IT department.

The surveys were then scanned using a system that allows data scanning from questionnaires generated outside the scanning software. The MHUS is particularly suited to this approach, as it is mainly composed of questions requiring a dichotomous response using a tick-box. There is a single question that allows significant amounts of free text to be entered.

Scanning errors were corrected during the process. The complete spreadsheet was then data checked against the hard-copy returned questionnaires. Once complete, this final spreadsheet was returned to the IT department, which then generated the demographic fields against the unique identifiers as a separate spreadsheet. These fields did not

include client names or addresses. These spreadsheets should then be returned to the Picker Institute, which is coordinating the NHS surveys overall.

Discussion

Despite initial concerns, undertaking a survey on this scale in a short time frame was remarkably trouble free. Conducting a large survey of this type can initially appear daunting. We would not advocate that trusts undertake this in-house unless they have adequate IT and clinical or research governance commitment. If this is established, we see no reason why these surveys cannot be conducted in-house.

Table 2 gives a breakdown of the staff costs of the survey. The costs of materials and printing amounted to £705.90. This includes the costs of the PO Box and Freepost licences. The estimated total cost for conducting the survey in-house is therefore £3230.90.

We expect the mandatory survey next year to take considerably less time, since the infrastructure and IT arrangements are now in place. The survey itself produced a 41% response rate after a reminder and repeat mail shots were sent to initial non-responders. The process produced 23 telephone enquiries, most of which were in fact to explain why a particular service client would find it

difficult to return the survey. Some clients were suspicious of the identification numbers and removed front sheets and questions, which rendered the returned survey unusable. Unfortunately, because of the restraints resulting from the MREC approval, we were unable to explain in the covering letter the purpose of the identifiers (i.e. to avoid clients receiving further surveys and reminder letters). We suggest that future covering letters for these surveys contain information explaining the need to be able to identify clients who have returned surveys.

The programme of mandatory NHS surveys can be undertaken using existing trust IT and management infrastructure. We found the exercise useful and informative because it demonstrated at a very practical level the use of IT systems to facilitate such an exercise. It also provided a useful opportunity for service users to be directly involved with a specific national project. There were considerable cost savings, although some quotes from

Table 2. Staff costs associated with the in-house survey

Category	No. of staff	No. of hours given	Costs (£)
Service user representative (volunteer)	1	–	Nil
Data input personnel	1	45	350
Clinical audit facilitators	2	25	450
Specialist information technology support staff	1	15	350
Departmental personal assistants	2	30	375
Executive director	1	2	50
Director of clinical governance	1	10	300
Manager of the adult mental health Care Programme Approach	1	22	300
Project manager	1	30	350
Total (for staff)	10		2525

commercial organisations matched our own estimates. However, using a commercial route does not absolve all trust staff from some involvement. Costs should be further reduced next year. The response rate was also encouraging. The data will be used locally to guide services as well as contributing to the national picture.

References

- Osbourne C, Magee H, Reeves R. *Development and Pilot Testing of the Questionnaire for Use in NHS Trust Based Mental Health Service User Survey*. Oxford: Picker Institute Europe, 2003
- Advice Centre for the NHS Patient Survey Programme. *Mental Health Service Users*. Oxford: Picker Institute Europe, 2003
- <http://www.nhssurveys.org>

The National Patient Safety Agency: an update

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- **The National Patient Safety Agency (NPSA) has developed seven steps to help NHS organisations improve patient safety and meet their clinical governance targets.**
- **Patient safety can be improved only in partnership with NHS staff.**
- **Patient safety can be achieved only through a change in both the culture and the systems in which staff work.**
- **The NPSA is about maximising local as well as national reporting and learning.**

Over the next month, the National Patient Safety Agency (NPSA) will be preparing to launch a patient safety campaign to raise awareness and describe current and future work which will guide and assist the NHS in making patient care safer. The campaign will be assisted by the publication of new best-practice guidance, *Seven Steps to Patient*

Safety. Over the next few months, the tools referred to in this paper will be placed on the NPSA's website (www.npsa.nhs.uk).

The seven steps

This paper briefly describes the NPSA's tools and techniques which will be made available as part of the patient safety campaign to assist the NHS in achieving the aims of the *Seven Steps to Patient Safety*. The seven steps are:

- **Build a safety culture** – patient safety must come first.
- **Lead and support your staff** – provide strong leadership, promote effective team working, and raise awareness and understanding of patient safety.
- **Integrate your risk management activity** – ensure that robust risk management structures and

processes are at the heart of the organisation.

- **Promote reporting** – report patient safety incidents both locally and nationally, and proactively identify risks in patient care.
- **Involve and communicate with patients and the public** – engage and communicate openly with patients, families, carers and the public to improve patient safety.
- **Learn and share safety lessons** – learn and share lessons from patient safety incidents.
- **Implement solutions to prevent harm** – implement sustainable solutions.

Creating a safety culture should be one of the priorities within the clinical governance and quality improvement programmes of the NHS. A safety culture is one in which safety is seen as a priority by the leaders of an organisation. It is not one person's job. Risks need to

be proactively identified, and when things go wrong managers need to be open with patients and fair to those who provide their care¹⁻⁴. The NPSA has developed a number of products which will help organisations develop a safety culture; these are discussed in the sections below.

Raising awareness

The NPSA has developed an induction video to be used by risk managers at an organisation's corporate induction. The video explains the systems approach to error, the role of the NPSA and the definitions of 'patient safety incidents' (this term has now replaced the term 'adverse events'). Detailed definitions of all the NPSA's terminology and guidance regarding 'near miss' data collection and risk matrices will be found in forthcoming guidance. The video is to be used in conjunction with local information, and will be backed up by a web-based tool entitled 'Introduction to Patient Safety: E-Learning', which offers detailed information on patient safety and the work of the NPSA.

Guidance and support

The NPSA has set up a network of patient safety managers, who will work within the geographical areas of each strategic health authority in England, and each region in Wales, and who will provide expertise and support as well as a crucial link between national and local perspectives. Through the network of patient safety managers, the NPSA aims:

- to assist organisations to meet targets set by the strategic health authorities and the Welsh Assembly regional offices;
- to help local organisations with external assessments, such as the Clinical Negligence Scheme for Trusts (CNST), the Risk Pooling Scheme for Trusts (RPST) and the Welsh Risk Pool (WRP);
- to support local risk management systems;
- to help local organisations achieve internal control, as part of the controls assurance procedures⁵.

By 2004 the NPSA aims to have developed a system of training for risk managers in patient safety.

The NPSA has also developed a 'Safety Toolkit for Leaders' and

checklists for team working. A guiding principle is 'If you're not sure it's safe, then it is not safe' and irrespective of your position you tell your superiors that you are not sure it is safe by whatever means are available⁶. Additionally, the NPSA aims to develop training programmes in 2004 to help those staff who have been given board responsibility for patient safety⁷.

Open and fair culture

A key part of any safety drive is an open and fair culture, whereby staff are open about incidents they have been involved in, feel able to talk to their colleagues and superiors about any incident, and are treated fairly. In February 2003, the NPSA Confederation jointly with the NHS launched a document which explores how to support a culture within which the NHS will encourage open reporting of incidents and determine system-wide accountability rather than simply apportioning individual blame⁸.

In addition, the NPSA has created a tool which will help NHS organisations to adopt the systems approach when deciding whether a staff member requires disciplinary action, known as the 'Incident Decision Tree'. This has been developed to encourage an open and fair culture, and is designed to prompt a series of questions to enable a systematic and consistent approach to staff, irrespective of organisation or profession. It is hoped that this tool will help to reassure patients and the public that there is a formal framework for assessing the culpability of individuals involved in patient safety incidents. The tool is currently being piloted in the acute sector of the NHS and the NPSA aims to have a final version on its website (www.npsa.nhs.uk) by spring 2004.

National Reporting and Learning System

To create a safer health-care system, the NPSA was tasked with establishing the National Reporting and Learning System (NRLS) for patient safety incidents. This system will be implemented across the NHS in England and Wales, so that by 2005 all organisations providing NHS-funded care will be capable of reporting to the NPSA. The NPSA's approach to introducing the NRLS is

to draw data from local risk management systems wherever possible, to avoid duplicate data entry and encourage the local reporting and investigation of incidents.

There are two main ways in which staff can report a patient safety incident: through the local risk management system; or directly to the NPSA via the electronic reporting form (eForm). Staff who report directly to the NPSA via the eForm are asked to share the information with their local organisation, whether identifiably or anonymously. All patient and staff information is anonymised before it reaches the NPSA database.

Being open

The NPSA is developing a policy for 'being open', which can be used as a model on which local organisations can base their own policies and procedures for being open⁹. The purpose of the model policy is to improve communication between health-care teams and patients (and their carers) following a patient safety incident that has led to moderate harm, severe harm or death.

The 'being open' policy should also be a vehicle for facilitating cultural change in the NHS (and the independent sector) towards a more open and honest approach when things go wrong during a patient's treatment. It is hoped that the development of local policies will help to increase patient and public confidence.

The policy will outline the levels of response appropriate to the type of incident, roles and responsibilities. It will advise that the following are given to patients who experience a safety incident:

- an acknowledgement and a factual explanation of what happened;
- an apology;
- an explanation as to the potential consequences and what steps are being taken to manage the incident;
- reassurance that lessons will be learned from the incident to reduce the chance of a recurrence.

Patient safety incident investigation analysis

The NPSA is advocating the use of significant event audit (SEA) and root cause analysis (RCA).

Significant event audit is used chiefly in primary care (see the paper by Stead and Sweeney in this issue, pp. 10–11); individual episodes in which there has been a significant occurrence (either beneficial or harmful) are analysed in a systematic and detailed way to ascertain what can be learned about the overall quality of care and to indicate changes that might lead to future improvements¹⁰.

Root cause analysis is a retrospective review of an incident to identify the sequence of events, working back from the incident, in the hope of identifying the root causes. The NPSA has developed an RCA e-learning toolkit, will be found on the NPSA website from December 2003. It will assist organisations in deciding the level of response, and guide both experienced and inexperienced staff through the use of the technique.

There will be a three-pronged approach to RCA training:

- *The RCA Foundation Programme* – a one-day familiarisation programme open to all trusts and other interested organisations. This will ensure that large numbers of health-care staff can access the NPSA training.
- *Network training*. Some trust personnel are specifically targeted with responsibility for all RCAs within their trust. These people will be interested in gaining more

detailed and extensive RCA knowledge, skills and experience.

- *Master classes*. These will be provided to those clinical governance leads and risk managers who wish to gain further knowledge and expertise in using RCA. These staff may well become national experts on RCA.

Solutions and alerts

The NPSA will use the information generated by the NRLS and other data sources to identify trends and patterns in patient safety incidents. The aims of solutions development are:

- to make it easy to do things right and difficult to do things wrong;
- to rectify incorrect actions.

Where there is a strong body of evidence that a particular approach will be effective in reducing the number of serious patient safety incidents, the NPSA will issue patient safety alerts with the expectation that the NHS will adopt the revised practice. The first of these concerned the storage of strong potassium chloride solutions. These alerts will, however, be few. More often the approach will be the development of 'toolkits', such as the infusion pump toolkit, which provides guidance to trusts on purchasing for patient safety, or evidence-based educational

Box 1. Questions to ask when considering solutions

- Consider the 'side-effects' of improvements – are we introducing more risk?
- Can the solutions be shared?
- Are they cost-effective?
- Are they realistic and sustainable?

packages that use simple, innovative techniques such as e-learning.

The NPSA is currently working on over 26 solutions for the NHS, examples of which can be found on the NPSA website. Box 1 lists the questions that need to be asked when considering solutions.

References

- 1 Schein E. *Organizational Culture and Leadership*. San Francisco: Jossey-Bass, 1985
- 2 Schein E. How culture forms, develops and changes. In: Kilmann R, Saxton M, Serpa R, eds. *Gaining Control of the Corporate Culture*. San Francisco: Jossey-Bass, 1985: 17–43
- 3 Reason J. Human error: models and management. *British Medical Journal* 2000;**320**: 768–70
- 4 Reason J, Hobbs A. *Managing Maintenance Error: A Practical Guide*. Aldershot: Ashgate Publishers, 2001
- 5 See www.controlsassurance.gov.uk
- 6 Sexton JB, Thomas EJ, Helmreich RL. Error, stress and teamwork in medicine and aviation: cross sectional surveys. *British Medical Journal* 2000;**320**:745–9
- 7 Department of Health. *Making Amends*. London: DoH, 2003. Available at www.doh.gov.uk/
- 8 NHS Confederation. *Creating the Virtuous Circle: Patient Safety, Accountability and an Open and Fair Culture*. London: NHS Confederation, 2003. Available at www.nhsconfed.org
- 9 Australian Council for Safety and Quality in Health Care. *Open Disclosure Standard: A National Standard for Open Communication in Public and Private Hospitals, Following an Adverse Event in Health Care*, Publication Number 3320. Canberra: Commonwealth of Australia, 2003
- 10 Pringle M, Bradley CP, Carmichael CM, Wallis H, Morre A. *Significant Event Auditing*. RCGP Occasional Paper 70. Exeter: Royal College of General Practitioners, 1995

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What can be done to increase incident reporting rates at the local level?

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- Under-reporting of adverse events is a serious issue facing health-care organisations.
- There are many barriers to incident reporting; the high levels of under-reporting suggest we do not fully understand these barriers and how to reduce them.
- The key to increasing reporting lies in more effective dissemination and use of incident reporting data at the local level.

In the UK, it is estimated that errors occur in 10.8% of hospital admissions¹. In view of this, how effective is incident reporting?

The extent of under-reporting

It is estimated that only 6% of all adverse events in the UK health-care system are reported². Indeed, studies comparing adverse events reported to incident reporting systems with those identified by retrospective record review suggest there are many more adverse events than are reported¹.

The reasons for under-reporting

Fear is one of the most common reasons for under-reporting (Box 1). There have been attempts to address the problem of fear as a barrier to reporting by using the systems approach to analysing error³. In other words, there has been a shift from focusing on the individual to focusing on the system for explaining the

causes of adverse events, and a shift to a low-blame/no-blame culture when investigating clinical incidents.

Professor Liam Donaldson (the Chief Medical Officer) drew up a joint declaration which highlighted this paradigm shift. One of the key pledges stated that:

failure should not be responded to primarily by blame and retribution, but by learning and by a drive to reduce risk for future patients.⁴

This is supported by the National Patient Safety Agency, which also stresses the need for a no-blame culture when addressing adverse events⁵.

It may well be possible to increase reporting levels through various training interventions, but how useful will the collection of all this data be? Effective use and feedback of incident reporting data are essential if any improvement in reporting rates is to be sustained, particularly at the local level. Indeed, poor feedback/dissemination of data is often given as a reason for not reporting incidents and, although there have been attempts to improve this locally, there is a need for a more integrated approach.

Varying administrative response is another reason for under-reporting of adverse events. All incident reporting systems have the ability to collect a substantial amount of data concerning adverse events. However, the evidence suggests that this information is not being used to its full potential and, indeed, is not reaching those who matter.

In fact, the data collected vary considerably between NHS trusts and even between the specialties within individual hospitals. In spite of collecting detailed information about adverse events, only 71% of trusts are able to provide data on the number of incidents within the last year and only 16% always provide feedback to the persons involved in the incident⁶ – a clear suggestion that data are not being used effectively.

Conclusion

Improving the usage and dissemination of data drawn from incident reports is key to improving rates of reporting at the local level. At present, a clear understanding of adverse events is hampered by the poor quality of data, primarily resulting from under-reporting. Effective use of incident reporting data and dissemination are imperative in order to illustrate to staff the impact that their reporting is having or could have on patient care.

References

- 1 Vincent C, Stanhope N, Corwley-Murphy M. Reasons for not reporting adverse incidents: an empirical study. *Journal of Evaluation in Clinical Practice* 1999;5:1–4
- 2 Joshi MS, Anderson JF, Marwaha S. A systems approach to improving error reporting. *Journal of Healthcare Information Management* 2002;16(1):40–5
- 3 Reason J. *Managing the Risks of Organization Accidents* 1997; Aldershot: Ashgate Publishers, 1997
- 4 Josefson D. Hospitals must inform patients of errors. *British Medical Journal* 2001;323:9
- 5 NPSA. *Doing Less Harm: Improving the safety and quality of care through reporting, analysing and learning from adverse incidents involving NHS patients – Key requirements for health care providers*. London: NPSA, 2001
- 6 Dineen M, Walshe K. Incident reporting in the NHS. *Health Care Risk Report* 1999; 5(4):17–22

Box 1. Reasons for under-reporting of adverse events

- Disagreement over what constitutes an error.
- Fear.
- Insufficient motivation to report incidents.
- Poor dissemination/feedback of incident data to staff.
- Variation in administrative response.

Significant event audit: a building block to developing a safety culture

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- Significant event audit (SEA) has been enjoying a revival since the advent of clinical governance and the patient safety agenda.
- Everyone in the health-care team benefits, through a sharing of learning, a nurturing of team relationships and progress towards a no-blame culture.
- Patients are the real beneficiaries of SEA, as a result of increased openness and the renewed focus on safety and risk minimisation.
- Some primary care teams are now involving patient representatives in their SEA meetings.

Significant event audit (SEA) has been used in general practice in various guises for nearly 20 years. The approach was made more structured by Pringle and his colleagues in the mid-1990s¹, but the advent of the safety agenda has really put SEA at the core of risk management processes. SEA is now a key component of the new General Medical Services (GMS) contract, contributes to GP appraisal procedures and is increasingly used by primary care teams and community hospitals^{2,3}.

Significant event audit is a multi-professional team activity, held on a regular basis (typically every four to six weeks), when incidents (both good and not so good) are discussed in a safe, supportive environment and the team generates solutions. The emphasis is on changing systems rather than apportioning blame. The focus on successes as well as failures gives the opportunity for teams to acknowledge that, in the main, they are doing a good job. SEA is *not* the forum in which to discuss serious adverse events or poor performance.

What constitutes a 'significant' event?

A significant event is one that in some way impacts either positively or negatively upon the smooth and safe running of the organisation.

Individuals in the team decide what is significant to them; there are no hard-and-fast rules about what can be included.

For example, one of the primary care teams that we observed undertaking SEA² discussed the practice receptionist's very successful handling of a clinical emergency that presented at the reception (a patient had swallowed a bee and went into anaphylactic shock). The event had been traumatic to the receptionist and the wider team (even though the patient survived), and was discussed as an opportunity for catharsis, congratulations, discussion of procedures and reassurance that team members could cope as well with a comparable event in the future.

One of the outcomes of the discussion was that some members of the team were conscious that they needed to update their first aid skills, and as a result of the discussion the practice manager set up a rolling programme of first aid training sessions for all staff at the practice.

While there are no hard-and-fast rules about what can be included in SEA, there are rules about what should *not* be discussed at an SEA meeting. As suggested above, issues that relate to professional performance or competency, or that could

cause embarrassment to the individual, should be dealt with in a more appropriate forum.

Getting started: the seven steps of SEA

It is helpful for a team to start with some external facilitation. In most areas, it is possible to access this type of support from the local education provider. The facilitator can guide the team through the seven steps of SEA.

(1) Logging events

The team needs to develop a system for logging events soon after they happen. Some use a computer log, others a judiciously placed notebook.

(2) Creating the agenda

Develop a healthy balance of good and not so good events, which are shared among team members. The agenda should be manageable, since SEA meetings should not last longer than an hour.

(3) Managing the meeting

The group needs a chair, to keep the discussion moving on. Leaders of SEA tend to emerge and are frequently not doctors. Another member of the team should keep

Box 1. The five categories of outcome for significant event audit

- **Congratulations.** Acknowledging that individuals in the team have done a good job.
- **Immediate action.** It is obvious what needs to be rectified and this is done straightaway.
- **Further work required.** A small sub-group needs to consider some complex issues, work on them and then bring them back to a future SEA meeting.
- **Further action is called for.** Further actions could include obtaining more information about a specific event, or there may be a clear need for a quality improvement project, separate from SEA activities.
- **No action.** There are not always answers to all incidents, but discussion of the issue is generally useful.

minutes (responsibility for this task can be rotated over time).

(4) Discussing the event

The person most involved in the incident should present the facts, and there should be opportunity for others to ask about issues of detail. Then a general discussion follows. Some positive element in the incident should be highlighted early on. There should be an emphasis on improving systems, not attributing blame.

(5) Deciding the outcome

There are only five broad areas of outcome (see Box 1): congratulations; immediate action; further work; further action; no action. There are not always answers to all incidents, but discussion of the issue is generally useful.

(6) Writing up the meeting

The minutes of the meeting are useful for a number of reasons:

- They provide a way of ensuring that action takes place and that the outcomes are reviewed.
- They are evidence of personal and team learning, and can be included in personal and team learning plans.
- They provide evidence that the team takes patient safety seriously.

(7) Sharing the learning with others

Increasingly, teams are prepared to share their learning from incidents with other teams in their area. A variety of methods have been developed for this, including newsletters and short presentations at clinical governance meetings. The key to sharing incidents and learning lies in the trust that has developed between the teams and the individuals in the primary care trust who take the lead for patient safety and governance.

Who benefits from SEA?

There are strong indications that SEA is beneficial to all health and social care teams, whatever the setting. The selling points are that it is about learning, mutual support, improving systems and building effective teams. The balance of sharing good and not so good issues nurtures team building, and the focus of the meeting is on patients and the improvement of their care.

Contributions

The audience is predominantly practising clinicians and managers, so please make your article as practical and relevant to everyday practice as possible.

Length: 500–800 words plus a maximum of five references in Vancouver (numerical) style.

Illustrations: where appropriate, use tables, charts, summary boxes etc. to present information, and to break up the text.

Web links: where possible, provide web and/or email addresses for further information – e.g. Department of Health reports or circulars, publications, societies, etc.

Presentation and submission: On the first page include the article title and author names and addresses (including email addresses); please also indicate which author is responsible for correspondence about the article and proofs. Start the article with three to five brief bullet points summarising the key lessons learned. Use plain, unjustified text throughout, with subheadings in bold upper and lower case.

Please send your contribution, by email (or by post with floppy disk), to:

Dr Myriam Lugon, Editor, *Clinical Governance Bulletin*,
email: MLugon@compuserve.com (or by post c/o Royal Society of
Medicine Press Limited, 1 Wimpole Street, London W1G 0AE).

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In some areas, people are considering how to involve patients in the process, for example by linking with the local Patient Advice and Liaison Service. This is a logical step after the team has matured and is able to share learning with other teams in the area. We will be able to say with confidence that 'SEA has truly arrived' when we can open these meetings to our patients and their carers.

References

- 1 Pringle M, Bradley CP, Carmichael CM, Wallis H, Moore A. *Significant Event Auditing: A Study of the Feasibility and Potential of Case-Based Auditing in Primary Medical Care*. Occasional Paper 70. London: Royal College of General Practitioners, 1995
- 2 Stead J, Sweeney G. *Significant Event Audit: A Focus for Clinical Governance*. Chichester: Kingsham Press, 2001
- 3 Westcott R, Sweeney G, Stead J. Significant event audit in practice: a preliminary study. *Family Practice* 2000;17:173–9

Book review

Quality Indicators for General Practice: A Practical Guide for Primary Health Care Professionals and Managers

Edited by M. Marshall, S. Campbell, J. Hacker and M. Roland.
ISBN 1-85315-488-1. pp. 208. £19.50.
London: RSM Press, 2002.

This is an important and timely book for GPs and their teams, as the new contract will surely change some of the emphasis given by GPs to quality indicators and their recording. It is

also a very practical book. It clearly outlines how the indicators were developed. The authors have used a rigorous and systematic way of combining expert opinion and scientific evidence. The result is thought provoking and aids reflection on some of the commonest conditions seen in general practice. The admission that many aspects of quality cannot be measured or may not have an evidence base can only give us confidence in this book.

The first two chapters give the background to the development of these indicators; the authors have made them easier to understand, and

they list key points at the beginning. They even outline in a box the problems of using quality indicators, which leaves the reader feeling that there is a sense of balance to this work.

The book tackles some of the most common and important areas of general practice, such as depression, coronary heart disease, asthma, hypertension and osteoarthritis. Acute low back pain, diarrhoea in children, dyspepsia and peptic ulcer disease, acute otitis media are also included among the 19 areas covered.

You do not have to read the whole book. The chapters are short and succinct. This is useful for busy practitioners, who may wish to scan through parts of the text on those areas they already feel confident

with. However, these chapters will nonetheless help practitioners to pick up points they had not thought about before and expand their understanding of the evidence available.

Trainers and registrars will find the book very valuable as a resource for tutorials, although it is primarily intended for health professionals and managers. One concern is that managers concerned with quality must understand the challenges faced by health practitioners in the implementation of these indicators.

Congratulations to all the contributors – the clear, concise presentation of the subject areas and references makes this book very useful. It is thought provoking and, like a good bestseller, it should be serialised so that it can be accessed

by a wider readership. I hope it reaches the wider audience – perhaps managers could make sure all GP tutors and appraisers get a copy.

Gouri Dhillon
GP, Ealing

Topics for future issues

- Quality versus quantity
- Providing incentives
- Quality in practice
- Working together
- Patients' perspective
- Introducing new procedures safely

See page 11 for guidance on the submission of contributions.

WhoWhatWhere?

Public involvement on the web

Advice Centre for the NHS Patient Survey Programme
www.nhssurveys.org

The role of the Advice Centre includes: identifying and developing questionnaires; providing documentation and advice on how to conduct the surveys; acting as a data centre to collate, check quality and analyse the survey data; and supporting health service providers to use the survey results to identify priorities for quality improvement in patient care.

Commission for Patient and Public Involvement in Health
www.cppih.org

This site explains what the Commission is all about.

Report of the House of Commons Health Committee
www.parliament.the-stationery-office.co.uk/pa/cm200203/cmselect/cmhealth/697/697.pdf

Seventh report of the session 2002–2003 on Patient and Public Involvement in the NHS.

The Editor's Choice

NHS Modernisation Agency: Improvement Leaders' Guides

www.modern.nhs.uk/improvementguides/patients/

This page provides links to a number of key documents for everyone involved in improving patient care and experience, including one entitled *Involving Patients and Carers*.

Pharmacy in the Future
www.rpsgb.org.uk/nhsplan/index.html

This website has a section dedicated to patient experience and public involvement, which gives some practical examples and access to relevant publications.

Patients Forum
www.thepatientsforum.org.uk/

The Forum provides a wide range of information relating to the patients' movement in the UK. This is primarily for member organisations, which represent the interests of people who use health services, to enable them to strengthen their work in informing and influencing decision makers.

NHS Patient Survey Programme
www.doh.gov.uk/Public/nhssurvey.htm

This site explains Department of Health policy and has useful links to other sites, including the results of earlier surveys.

International Alliance of Patients' Organizations (IAPO)
www.patientsorganizations.org/

The IAPO is a global alliance representing patients of all nationalities across all disease areas and promoting patient-centred health-care around the world.

Why not email us your suggestions?

If you know of any useful websites, please email the editor.