

Strategic health authority involvement in patient safety

Introduction

Between January and February 2005, the National Audit Office conducted semi-structured telephone interviews with strategic health authorities about their monitoring, performance feedback, arrangements for learning and training for patient safety. Twenty-seven out of the 28 the leads on patient safety responded to us and this provides a summary of the main findings.

Monitoring

- All patient safety leads perform some monitoring activities of individual trusts:
 - Four met/ worked with clinical governance leads on a planned basis
 - Half examined clinical governance development plans and reports
 - All but one collected reports on serious untoward incidents and most log responses of compliance to the Safety Alert Broadcast System, but varying use is made of the information submitted
- At best this use will be the review of the outcome reports and action plans of the incidents and the running of trend analysis on all serious untoward incidents to identify areas requiring further investigation, for example maternal deaths. At worst no analysis is undertaken and some questioned whether it was an appropriate role for strategic health authorities now.
- Eight strategic health authorities provided specific examples of action they had taken as a result of concerns about patient safety incident(s) in particular trusts.
- Those incidents where the competence of a healthcare professional was called into question were often mentioned as a trigger for an intervention.
- All but two of the remaining strategic health authorities would follow-up on a patient safety incident if it met certain criteria. Commonly this was if:
 - the information provide by trusts was insufficient or inconsistent;
 - the investigation did not get to the root cause; or
 - the action plan was not implemented.
- Very few strategic health authorities monitor the implementation of good practice. Generally it is confined to following up action plans for serious incidents and the checking of clinical governance development plans and reports. Many felt that they did not have the capacity/ capability to be able to perform this role.

Performance Feedback

- All but three strategic health authorities feedback on their monitoring of performance on patient safety. Five strategic health authorities indicated that they gave anonymised

summaries of serious untoward incidents - ranging in frequency from weekly to bi-annually. Typically, however, feedback related to the serious untoward incidents within the particular trust or on the clinical governance development plans, etc.

Arrangements for Learning

- Only three strategic health authorities do not have a system in place to facilitate the sharing of learning from incidents between trusts in their region. Two of these have plans to begin network events in the future.
- Fifty-six per cent of strategic health authorities use a forum to disseminate lessons; 20 per cent use bulletins or e-based notification.
- None of the strategic health authorities had a fully integrated system to learn from serious untoward incidents, complaints and litigation cases - in some cases because these are dealt with by different parts of the strategic health authority, but mostly because complaints and litigation cases are not monitored for the learning they can provide.

Training

- Just over half the strategic health authorities rely on other organisations to facilitate training in the patient safety arena.
- Trusts in those areas where strategic health authorities still take a lead can participate in:
 - Workshops on reporting requirements and responsibilities;
 - Clinical governance development programmes and celebrations of good practice; and
 - Network events and conferences to raise awareness and platform key issues, often with external speakers.

Links with the National Patient Safety Agency

- Root cause analysis training has resulted in good links between the National Patient Safety Agency and strategic health authorities and in a number of areas the new Patient Safety Managers have desks in strategic health authority offices.
- There are tensions. strategic health authorities are concerned that:
 - There is duplication between the Strategic Executive Information System and the National Reporting and Learning System;
 - Not enough learning is coming out of the centre;
 - Foundation trusts may chose to opt out of local networks;
 - There is no clear agency tasked with enforcement; and
 - The inclusion of the remit of the National Clinical Assessment Authority may be perceived as a return to the 'blame culture'