How often do doctors report serious clinical incidents? A comparison to other healthcare workers and the experience of clinical incident reporting in the NHS.

Habib Rahman[1] and Nicki Cornford[2]

[1]Affiliation not available
[2]Eastbourne District General Hospital

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Abstract

Rationale, aims and objectives: Clinical incident reports are the primary means by which UK hospitals are alerted to avoidable harm in healthcare. However, data demonstrating the patterns in real-world reporting by healthcare workers have never been published in the UK. Though this journal has previously published survey data describing the discrepancies between respondents' own behaviour compared to the incidence of perceived avoidable harm, we set out to collect data on actual reporting patterns between healthcare workers. Given the concerns raised by Robert Francis following the Mid-Staffordshire Inquiry, we specifically wished to examine the rate of reporting of doctors compared to other healthcare workers. Methods: We selected for incidents causing at least 'moderate' levels of harm, theorising that such levels of harm are most likely to be noticed by doctors. Data from 2011 to 2019 from the clinical governance departments of 2 NHS hospitals was requested and all available data subsequently charted. Results: This is the first study examining NHS incident reporting patterns in the medical profession. We demonstrated a stark level of underreporting of clinical incidents causing harm ranging from 'moderate' to death by doctors. This was particularly dramatic at the non-consultant grade level. In 1 hospital, only 2 deaths were reported by non-consultant grade doctors in 6 years. Notably 1 hospital had not stored any incident reporting data until 2017. Conclusion: The reporting behaviour of doctors has not significantly changed despite the Francis Reports. This could be improved by creating incentives for doctors to engage with patient safety initiatives and disclosure of error, as well as the use of automated systems.

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