**Can the NHS make improvements to patient safety?**

Emeritus Professor Alan Glasper, from the University of Southampton, discusses the latest initiative from secretary of state Jeremy Hunt which seeks to foster a culture within the NHS which relies on learning from mistakes and not apportioning blame to individuals.

**Introduction**

At the Global Patient Safety Summit held in London on the 9th and 10th March 2016 health secretary Jeremy Hunt gave a speech in which he committed his government to action to prioritise patient safety in the NHS through three important announcements.

<https://www.gov.uk/government/speeches/from-a-blame-culture-to-a-learning-culture>

Delegates at the summit included health ministers and senior expert clinicians from across the world including Dr Margaret Chan, Director General of the World Health Organisation who has an extensive background in world public health. In his speech to summit delegates the health secretary firstly announced the formation of an independent Healthcare Safety Investigation Branch (HSIB) and importantly legal protection to whistle blowers who expose and escalate information pertinent to clinical and other incident mistakes which will protect them from potential retribution in the work place.

HSIB will commence operations in April 2016 and will offer support and guidance to NHS organisations on how to conduct investigations, in addition to conducting its own.

<https://www.gov.uk/government/groups/independent-patient-safety-investigation-service-ipsis-expert-advisory-group>

The primary aim of HSIB will be to fully investigate any patient safety incident that is referred by taking a non-punitive approach. Importantly its practices and recommendations will be intended for learning and improvement, not to find fault, attribute blame or hold people to account.

Secondly Jeremey Hunt used to summit to announce that NHS trusts and foundation trusts will be publically ranked on their openness and transparency under a new ‘[Learning from mistakes league](https://www.gov.uk/government/publications/learning-from-mistakes-league)’ launched by Monitor (the health regulator which ensures that independent NHS foundation trusts are well-led so that they can provide quality care on a sustainable basis) and the NHS Trust Development Authority (TDA) (which provides support and governance for all other non-foundation NHS Trusts.)

 <https://www.gov.uk/government/news/new-league-launched-to-encourage-openness-in-the-nhs>

**NB** in April 2016 Monitor and the TDA will merge to become a new body entitled NHS Improvement.

 <http://www.nationalhealthexecutive.com/News/nhs-improvement-to-replace-monitor-nhs-tda-by-april-2016/119160>

Data analysis from the 2015 NHS staff survey and from the National Reporting and Learning System (NRLS) has shown that:

* 18 providers were outstanding
* 102 were good
* 78 gave cause for significant concern
* 32 had a poor reporting culture.

 <https://report.nrls.nhs.uk/nrlsreporting/>

The [Learning from mistakes league](https://www.gov.uk/government/publications/learning-from-mistakes-league) is adamant that learning from mistakes does save lives and that in order to fully learn from mistakes the creation of a culture with openness and transparency at its heart in fundamental. This new organization believes that by informing NHS Trusts of how well they are performing compared with their peer trusts will drive up safety standards.

Thirdly the Health secretary has announced the introduction of medical examiners from April 2018 to independently review and confirm the cause of all deaths.

https://www.rcpath.org/discover-pathology/news/college-welcomes-medical-examiners-announcement-.html

This was anticipated as independent medical examiners were first recommended following the 2005 inquiry into the murders of patients by Dr Harold Shipman

[http://webarchive.nationalarchives.gov.uk/20090808154959/http:/www.the-shipman-inquiry.org.uk/reports.asp](http://webarchive.nationalarchives.gov.uk/20090808154959/http%3A/www.the-shipman-inquiry.org.uk/reports.asp)

and following Sir Roberts Francis’s [inquiry into the scandal which occurred at the Mid-Staffordshire NHS Foundation Trust](http://www.nationalhealthexecutive.com/Health-Care-News/mid-staffordshire-nhs-trust-will-be-dissolved/66534). The health minister is optimistic that the introduction of medical examiners will improve the national health services ability to learn from unexpected or avoidable deaths.

[http://webarchive.nationalarchives.gov.uk/20150407084003/http://www.midstaffspublicinquiry.com/](http://webarchive.nationalarchives.gov.uk/20150407084003/http%3A//www.midstaffspublicinquiry.com/)

**Background**

In his speech the health secretary reminded delegates that every week in the NHS there are potentially 150 avoidable deaths and he is anticipating that the NHS will transcend from a historical blame culture to a learning culture. He aspires to change the UK health service as it evolves into a new organization built on openness to become the safest healthcare system in the world. He believes that much progress has already been made in the intervening years since the public became aware of the catastrophic failures of the Mid Staffordshire NHS Foundation Trust. The Secretary of States’ aspiration for an NHS which can offer 24/7 safe care can only occur if the current NHS stops its quick fix blame culture where a succession of senior executives fall on their metaphorical swords and accept and acknowledge that sometimes serious mistakes can be made by hardworking and loyal patient advocates from a variety of health care professions. The English poet [**Alexander Pope**](http://www.poets.org/poet.php/prmPID/1566) reminds us that *“to err is humane, to forgive, divine”* and that everyone makes [mistakes](https://en.wiktionary.org/wiki/mistakes).

 <http://poetry.eserver.org/essay-on-criticism.html>

The Care Quality Commissions (CQC) already examines safety when conducting their inspections of hospitals. Hospital inspectors and their specialist advisors gather evidence from 5 key areas when seeking to assure themselves that a care organization is safe.

1. Are lessons learned and improvements made when things go wrong?
2. What is the track record on safety? In the context of these first two aspects of safety, data will be gathered on the safety performance of an institution over time. To illuminate this CQC staff will investigate any never events (i.e. patient safety incidents that should not have occurred if the available preventive measures have been implemented) and staff will be interviewed to ascertain if they understand their roles and responsibilities to raise and escalate concerns about patient safety including near misses. Staff will also be questioned about their roles in implementing the duty of candour. It is how the institution behaves when things go wrong which interests the CQC and their staff will seek reassurances that lessons learned from safety incidents are cascaded appropriately to prevent reoccurrence. The CQC also seek evidence of the use of patient safety thermometers such as early warning score protocols and the use of SBAR (The Situation, Background, Assessment and Recommendation technique) (<http://www.institute.nhs.uk/safer_care/safer_care/situation_background_assessment_recommendation.html>) and and other patient safety models for example as in the use of the sepsis 6 care bundle which has been shown to reduce the relative risk of death by 46.6 % (<https://www.england.nhs.uk/wp-content/uploads/2014/02/rm-fs-10-1.pdf>)
3. A key area investigated by the CQC when examining safety is the effectiveness of mandatory training in safety systems, processes and practices. This is especially true of safeguarding where evidence to show that vulnerable service users are protected will be gathered. Similarly the CQC will gather data on how cleanliness, infection control and hygiene are managed and that the environment and the equipment used within clinical domains is fit for purpose and importantly conforms to relevant safety standards.
4. The assessment of and the management of patient risk is another crucial area examined by the CQC. Staffing levels and the appropriate rostering of members of the multidisciplinary team features largely in this part of a CQC inspection. In this situation inspectors will compare actual staffing numbers with those recommended by accredited bodies such as the Royal College of Nursing who have formulated for example safe staffing ratios for the care of sick children in hospital.(RCN 2013) <https://www.rcn.org.uk/professional-development/publications/pub-002172.> Given that nurses make up the largest component of the NHS workforce it is not surprising that the CQC examine nurse staffing levels in significant detail as a measure of patient safety. In his written submission of evidence to the health and social care committee of the National Assembly for Wales Consultation on the Safe Nurse Staffing Levels (Wales) Bill, Professor Peter Griffiths, who holds the Chair of Health Services Research at the University of Southampton highlighted the extensive evidence that shows that lower levels of nurse staffing in hospitals are associated with poorer patient outcomes.(Griffiths et al 2014) <http://www.senedd.assembly.wales/documents/s36470/HSC4-05-15%20Paper%202.pdf>
5. The final area of safely investigated in any CQC inspection of a hospital is how well the institution is prepared to deal with potential risks to the service and if these risks are anticipated and planned for in advance. For example the Royal Free Hospital in London was able to offer suitable facilities for the treatment of patients who were infected during the Ebola epidemic. (Jacobs et al 2014)

**Discussion**

As part of his plan for a safer NHS, 7 days a week, the Health Secretary announced that:

* The General Medical Council and Nursing and Midwifery Council will amend their guidance to registrants so that when a member is honest about a mistake they have made and apologizes, a subsequent professional tribunal will award them credit for that admission, but if that registrant fails to do so they will be more likely to have a more serious sanction incurred.
* The new body NHS Improvement will require all NHS Trusts to publish a charter for openness and transparency so that all staff members have unequivocal expectations of how they will be treated if they witness clinical errors in practice.
* NHS England will work with the Royal College of Physicians to develop a standardized method for reviewing the records of patients who have died in hospital
* England will become the first country in the world to publish estimates by every hospital trust of their own – non-comparable – avoidable mortality rates

<https://www.gov.uk/government/speeches/from-a-blame-culture-to-a-learning-culture>

In his speech Jeremy Hunt told members of the summit that an estimated 1 million patients die in hospitals across the world every year because of avoidable clinical incidents. Although he admitted that this data cannot be verified because of the variability in reporting standards across the world, were it to be of the scale estimated it would put deaths from clinical incidents in the same league as deaths from road accidents.

He also cited the work of Hogan et al (2015) which investigated the avoidability of hospital deaths in England. This seminal retrospective case record review suggested that 3.6% of hospital deaths have a 50% or more chance of being avoidable which represents a potential of 150 avoidable deaths every single week. To illustrate the scale of the problem the health secretary reminded his audience of the case of Wayne Jowett, a young man with acute lymphoblastic leukaemia who died in January 2001 at the Queens Medical Centre in Nottingham after been wrongly administered with an intrathecal drug which was intended to be given intravenously

<http://www.smd.qmul.ac.uk/risk/yearfive/casestudies/wayne-jowett.html>

Not only did the young man die but the professional life of the young doctor who incorrectly administered the drug was left in taters and he spent 11 months incarcerated in prison. Although it was the doctor who gave the drug incorrectly Wayne's death was actually attributed to a series of accidental mistakes and systems failures which is known as the Swiss cheese effect. This phenomenon is where everything seems to go wrong and the holes in the slices of Swiss cheese line up to facilitate a route of calamity opportunity through which harms can be perpetrated upon the unintended victim, in this case a young man. In this “never event”, the “holes in the cheese” which were failures in the chemotherapy system used at the hospital actually involved pharmacists, nurses and medical staff. Tragically as the whole legal process continued with the doctor languishing in prison exactly the same error was made in another NHS hospital and another patient died because according to the health secretary, the English system was more interested in blaming than learning! He believes that there is too much avoidable harm and death in the NHS and that all health care professionals need ascertain the cause of blockages in the development of a supportive, learning culture to make hospitals as safe as they should be.

**Conclusion**

Jeremy Hunt sees that profound culture change is necessary to ensure that the NHS completes its journey in making the changes from a blame culture to a learning culture. It will be through the range of measures being introduced that will lead to the intelligent transparency needed to make the changes necessary for improved patient safety. Furthermore the CQC chief Inspector of hospitals Sir Mike Richards intends to incorporate a range of indicators in hospital inspections including staff survey measures of how supported frontline staff feel if they raise safety concerns and whether staff feel able to contribute towards improvements in their work place. The health secretary has admitted that safer care requires more NHS resources, but points out that unsafe care is even more expensive costing the NHS up to £2.5 billion a year, attributed to longer hospital stays, repeat visits and expensive litigation. Nurses and other health professionals will welcome these proposals which offer service users the safe high quality care they deserve.

**Key points**

* Secretary of State Jeremy Hunt has committed his government to action to prioritise patient safety in the NHS.
* Legal protection will be given to whistle blowers who expose and escalate information pertinent to mistakes which will protect them from potential retribution in the work place.
* The Nursing and Midwifery Council will soon amend their guidance to registrants so that when a member is honest about a mistake they have made and apologizes, a subsequent professional tribunal will award them credit for that admission,
* Extensive evidence that shows that lower levels of nurse staffing in hospitals are associated with poorer patient outcomes

**References**

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