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Committee of MPs slam NHS approach to patient safety July 2009

On 3 July 2009 the House of Commons Health Committee issued a report setting out their conclusions on patient safety. Over the past 12 months the committee has received evidence from a wide variety of organisations and individuals concerned with patient safety, from senior DH officials, regulators and academics to patient groups, charities and individual patients and relatives.

They concluded that patient safety was multifaceted and that, having examined in some detail what they regarded as the most important issues, there were significant deficiencies in current policy. They have recommended several changes that need to be made in order for there to be further progress in tackling unsafe care.

Whilst highlighting some areas of good practice the committee were highly critical of many aspects of the NHS's current approach to patient safety, concluding that there has been "insufficient progress in making services safer" and that there "are significant deficiencies in current policy".

Particular criticism was levied at government policy stating that it "has too often given the impression that there are priorities, notably hitting targets (particularly for waiting lists, and accident and emergency waiting), achieving financial balance and attaining foundation trust status, which are more important than patient safety. This has undoubtedly, in a number of cases, been a contributory factor in making services unsafe."

Even Monitor came in for direct criticism. In respect of the case of Mid-Staffordshire NHS Foundation Trust the committee concluded that: "Not only did Monitor fail to detect unsafe care—it effectively allowed the trust to compromise patient safety in premature pursuit of foundation status. We note the Healthcare Commission found that achieving foundation status was one of the factors that distracted the trust from patient safety issues. Monitor's acceptance at face value of the trust's excuse that its poor mortality figures were a statistical anomaly is wholly unacceptable."

In summary the committees' recommendations were that:

- A review of sample patients' case notes at periodic intervals should be undertaken by all hospitals and data gathered together by the NPSA.

- Patient advice and liaison services should be provided independently of the NHS organisations to which they relate; and the independent review stage of the complaints process should be reinstated.

- Particularly recommend the decriminalisation of dispensing errors on the part of pharmacists.

- More data collected by the NRLS should be published.
- The NRLS should gather more in-depth information on serious and sentinel events.
- There must be much wider, and better, use of root-cause analysis.
- The NPSA must now collate data from a variety of sources not just reporting data.
- There are serious deficiencies in the undergraduate medical curriculum which must be addressed in the next edition of Tomorrow's Doctors.
- Patient safety must be fully and explicitly integrated into the education and training curricula of all healthcare workers. In addition, there must be more interdisciplinary training, those who work together should train together.
- Linking payment by PCTs to the quality of care and "Never Events" should be piloted.
- DH produce a formal definition of the performance-management role of strategic health authorities (SHAs).
- The Care Quality Commission's registration system must focus on the outcomes rather than governance processes.
- The DH should produce a succinct statement regarding how commissioning, performance management and regulation are defined, and how they relate to each other.
- Boards should receive specialist training on patient safety, particularly non-executive directors.
- Patient safety must be the top priority of boards and, to show this, it should without exception be the first item on every agenda of every board.
- NHS organisations should consider the measures piloted as part of the Safer Patients Initiative.
- No board in the NHS should always be meeting behind closed doors.
- The DH should bring forward support for whistleblowing.
- All government policy in respect of the NHS must be predicated on the principle that the first priority, always and without exception, is to ensure that patients do not suffer avoidable harm.
- The key tasks of the Government are to ensure that the NHS:
    - develops a culture of openness and "fair blame";
    - strengthens, clarifies and promulgates its whistleblowing policy;
    - provides leadership which listens to and acts upon staff suggestions for service changes to improve efficiency and quality; and
    - by the provision of examples and incentives, encourages and enables staff to implement practical and proven improvements in patient safety.

- The Government should examine the contribution of deficiencies in regulation to failures in patient safety.

Conclusions

The report itself makes interesting reading and is a must for all clinical and managerial staff in the NHS. It is however noticeable that the committee has taken much of the submissions to it at face value and have not taken the opportunity to consider the underlying methodology behind patient safety. It still takes as its basic tenet that the route to patient safety is to learn from mistakes. Despite many anecdotal references to good practice in the aviation industry, they have not examined the basic methodology for managing safety used outside of the NHS. In all other industries, including aviation, the emphasis is on preventing the plane crashing in the first place rather than picking over the wreckage with promises to do better next time.

This is the perfect time for all NHS trusts to stand back from the myriad of targets, standards and directions that come from the packed field of regulators and supervisory bodies and consider how they can focus on patient safety and made a real difference in the provision of safe care in their own organisation.

Mills & Reeve can offer a number of solutions to help you address safety and governance within the healthcare sector.

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