BUDDLEFINDLAY

Legal update - A promise to learn – a commitment to act: Berwick report published

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On 6 August 2013 an independent national advisory group in the United Kingdom, led by Don Berwick, released its report on the lessons learned in the wake of the Mid-Staffordshire tragedy, and the actions needed to respond. At the outset, the report comments:

"The only conceivably worthy honour due to those harmed is to make changes that will save other people and other places from similar harm. It would add tragedy to tragedy if the nation failed to learn from what happened, and to put those lessons to work."

While the report is focused on how to improve patient safety and the quality of care in the NHS in England, the lessons are applicable to other healthcare systems, including in New Zealand.

Improving the safety of patients

The national advisory group studied the various accounts of services at Mid-Staffordshire, as well as the recommendations of Robert Francis QC in his Public Inquiry Report, with the aim of distilling the lessons learned and specifying the changes needed.

The report emphasises the importance of having patient safety as the ever-present concern and top priority of every person working within the healthcare system, and the need to embrace a culture and ethic of learning, recognising that "*the battle for safety is never "won"; rather, it is always in progress*".

The report acknowledges that regulation does have an important role in setting expectations, monitoring compliance, and taking action when expectations are not met, but concludes that: "*in the end, culture will trump rules, standards and control strategies every single time, and achieving a vastly safer NHS will depend far more on major cultural change than on a new regulatory system*".

The report set out a number of recommendations to help effect cultural change, including recommendations for leadership, public and patient involvement, and safe staffing. In addition to those working in the health care system, the report notes that society generally, and leaders and opinion formers in particular (including national and local media, national and local politicians of all parties, and commentators), have a crucial role to play in shaping a positive culture and building on existing strengths: "*Where people find themselves working in a culture that avoids predisposition to blame, eschews naive or mechanistic targets, and appreciates the pressures that can accumulate under resource constraints, they can avoid the fear, opacity, and denial that will inevitably lead to harm*".

A summary of the problems identified by the national advisory group, the solutions to address these problems, and the report's key recommendations for action, are set out below.

The problems

The following key problems were identified:

- **Patient safety problems exist throughout the NHS, as with every other health care system**.
- **Staff are not to blame**: Staff want to do a good job, reduce suffering and be proud of their work. It is the systems, procedures, conditions or environments and constraints they face that lead to patient safety problems in the vast majority of cases.
- **Incorrect priorities do damage**: In some organisations the goals of hitting targets and reducing costs have taken centre stage: "*Although other goals are important, where the central focus on patients falters, signals to staff, both at the front line and in regulatory and supervisory bodies, can become contaminated. Listening to and responding to patients' needs then become, at best, secondary aims. Bad news becomes unwelcome and, over time, it is too often silenced. Under such conditions organisations can hit the target, but miss the point*".
- **Warning signals abounded and were not heeded**: Information about the deterioration of the quality of care at

Mid-Staffordshire appeared in both narration (complaints from staff, carers and patients) and quantitative metrics (mortality rates). Despite this, "*loud and urgent signals were muffled and explained away*".

- **Responsibility is diffused and therefore not clearly owned**: Responsibility for oversight and remedy of quality and safety concerns was diffused and divided among many agencies: "*When so many are in charge, no one is*".
- **Improvement requires a pattern of support**: "*The capability to measure and continually improve the quality of patient care needs to be taught and learned or it will not exist*".
- **Fear is toxic both to safety and improvement**: Fear impedes improvement, and this was clearly seen at Mid-Staffordshire where "*Better not to know*" became the order of the day: "*A symptom of this cycle is the gaming of data and goals; if the system is unable to be better, because its people lack the capacity or capability to improve, the aim become above all to look better, even when truth is the casualty*".

The solutions

The report notes that the above problems are not unique to the NHS; they occur in all large healthcare systems. Recognising that they are problems is the first step towards repair as "*knowing what is wrong gives us the opportunity to set things right*".

To address these issues, the system must:

- Recognise with clarity and courage the need for wide systemic change
- Abandon blame as a tool and trust the goodwill and good intentions of the staff
- Reassert the primacy of working with patients and carers to achieve health goals
- Use quantitative data with caution. Such goals do have an important role en route to progress, but should never displace the primary goal of better care
- Recognise that transparency is essential and insist on it
- Ensure that responsibility for functions related to safety and improvements are vested clearly and simply
- Give people career-long help to learn, master and apply modern methods for quality control, quality improvements and quality planning
- Make sure pride and joy in work, not fear, infuse the healthcare service.

Key recommendations

The report concludes that the most important single change in the NHS is "*to become, more than ever before, a system devoted to continual learning and improvement of patient care, top to bottom and end to end*".

The specific recommendations made are:

- **Ethic of learning**: The NHS should reduce patient harm by embracing an ethic of learning.
- **Leadership**: All leaders concerned with healthcare - political, regulatory, governance, executive, clinical and advocacy - must place quality of care in general, and patient safety in particular, at the top of their priorities for investment, inquiry, improvement, regular reporting, encouragement and support.
- **Patient and public involvement**: Patients and their carers should be present, powerful and involved at all levels of healthcare organisations from wards to the boards of Trusts.
- **Safe staffing**: Both the Government and Healthcare organisations should ensure that staff are present in appropriate numbers, both now and in the future.
- **Training and capacity building**: Quality and patient safety should be part of initial preparation and lifelong education of all health care professionals, including managers and executives. Leaders should create and support the capability for learning, and therefore change.
- **Transparency and measurement**: Transparency should be complete, timely and unequivocal. All data on quality and safety should be shared in a timely fashion. All organisations should seek out the patient and carer voice as an essential asset in monitoring the safety and quality of care.
- **Structures and regulation**: Supervisory and regulatory systems should be simple and clear. They should avoid diffusion of responsibility. They should be respectful of the goodwill and sound intention of the vast majority of staff.
- **Enforcement**: Regulation of organisations should be responsive and should allow for a hierarchy of responses. Recourse to criminal sanctions should be extremely rare, and should function primarily as a deterrent to wilful or reckless neglect or mistreatment.

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