Excerpts from the House of Commons Health Committee inquiry into "Patient Safety", published 3 July 2009

The Committee published 59 recommendations, a number of which refer specifically to actions that the CHFG have strongly advocated in either written or oral evidence; or through public statements. Eight significant recommendations are reproduced below, followed by some quotes that attracted our attention. However, it is a complex and insightful paper that can only be fully appreciated when read in full.

Recommendations

Para 117. [..] We also recommend that root-cause analysis be undertaken much more widely, and better, in the NHS in respect of serious and sentinel events in general and less common types of these in particular. We believe this might be facilitated by the establishment of a body along the lines of the Department for Transport's Accident Investigation Branches, which could undertake independent root-cause analysis of serious and sentinel events in cases where there are likely to be significant new lessons to learn. In cases involving a patient's death this could have the additional benefit of providing their family with the full explanation that coroners do not seem always to provide. We recommend that the DH look into the feasibility of this.

Para 151. Lack of non-technical skills can have lethal consequences for patients. However, the NHS lags unacceptably behind other safety critical industries, such as aviation, in this respect. Human Factors training must be fully integrated into undergraduate and postgraduate education, as we discuss more fully below.

Para 195. There are serious deficiencies in the undergraduate medical curriculum, which are detrimental to patient safety, in respect of training in: clinical pharmacology and therapeutics; diagnostic skills; non-technical skills; and root cause analysis. These must be addressed in the next addition of *Tomorrow's Doctors*. The DH and GMC must monitor the quality of new medical graduates' use of the skills listed above. Elements of patient safety are taught, but this tends to be done implicitly rather than explicitly; this should also be addressed in the curriculum, which must make clear that patient safety is the first priority of medical practice. Patient safety must also be fully integrated into postgraduate medical education and training as a core element, not an optional extra.

Para 196. Patient safety, including Human Factors, has yet to be fully and explicitly integrated into the education and training curricula of healthcare workers in general. This training should include the recognition that errors will inevitably occur in certain circumstances. There are convincing arguments for interdisciplinary training to foster good teamwork skills across professional boundaries: those who work together should train together.

Para 290. Many managers and non-executive members of Boards with responsibility for patient safety seem to have little or no grounding in the subject. There is a case for providing specialist training in patient safety issues, particularly to non-executives, to help them scrutinise and hold to account their executive colleagues. We agree with Lord Patel's suggestion about giving one non-executive member of each Board specialist training, to allow them to take particular responsibility for it. The example

of Luton and Dunstable Hospital in having committees of the Board of Directors to look specifically at patient safety and patient experience should be recommended to all Trust boards.

Para 291. Patient safety must be the top priority of Boards. In order to fulfil their duty to ensure "that the quality and safety of patient care is not pushed from the agenda by immediate operation issues", patient safety should without exception be the first item on every agenda of every Board.

Para 292. We commend to NHS organisations the measures piloted as part of the SPI to ensure that Boards maintain safety as their foremost priority, namely

- implementing tried and tested changes in clinical practice to ensure safe care;
- banishing the blame culture;
- Providing the leadership to harness the enthusiasm of staff to improve safety;
- changing the way they identify risks and measure performance, by using information about actual harm done to patients, such as data from sample note reviews.

We strongly urge adoption of these throughout the NHS.

Para 293. In addressing the blame culture, we recommend that Trusts use means such as the Texas Safety Climate Survey to measure and monitor how far staff feel confident about being open and reporting incidents.

Some quotes....

Finally a few quotes taken from the report which seem appropriate:

"Greater openness about, and reporting of incidents, combined with determined searching for systemic faults, enables lessons to be learned and implemented with tangible improvements in safety. In this respect, healthcare needed to catch up with other safety-critical industries, such as civil aviation, where this approach has become well established."

From Professor Sir Ian Kennedy:

"If I could draw a distinction between what I would call structural responses, which have been quite significant, the creation of the NPSA, the National Patient Safety Forum and other such exercises, Darzi's review, and so on, contrast that with cultural changes and behavioural changes and I think they lag behind in translating ideas into reality."

From Professor Brian Toft:

"It should be in medical student training. Right from the very beginning that they start their training there should be a gradual build up of notions of error, how human error is created, how the whole system works together, how it leads to the creation of errors but, most importantly, everybody should be told directly that nobody is perfect – nobody."

From Dr Long:

"I can only talk for my training, obviously. I qualified in 2002, so I started my training in 1994, in the old-style system, I think. Although I knew safety was of crucial importance, that everything I was learning so that I could treat my patients safely, it was never really made explicit. I never really heard the expression "patient safety". The only thing I can vaguely remember is a talk given to us as undergraduates by one of the defence unions about prescribing safely and trying to avoid complaints. When I qualified, I was always very worried about making mistakes, but I never really stepped back and thought about why mistakes might occur or what the consequences might be or anything like that."

From Imperial College:

"Interviewees were asked if they had any training or education about patient safety. It seems that some of the interviewees seemed confused about what actually constituted as 'patient safety training'. Some spoke about fire safety training, risk management or perhaps training in reporting incidents but few actually specified they had patient safety training."

Lord Darzi:

"How do we align all of these people together with the ultimate aim of improving safety and quality? If I could bring you back to accountability – I think Liam[Donaldson] said this earlier – someone needs to be out there accountable for core standards of safety and quality. That should be just one, and that will be the CQC and only the CQC. Anything above core standard, everyone who wants to be on the pitch, they should start talking about quality improvements..."

From the recommendations:

"Relative have the right to expect that coroner's inquiries will provide information about the reasons for deaths. We are disappointed that some harmed patients' families do not believe that coroners provide the objective inquiry and independent review that is needed. We believe coroners are too narrowly focussed on the immediate cause of injury rather than underlying causes, as evidenced by the case of Bethany Bowen."