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Editorial

Action and learning for safer healthcare systems

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Two key reports have been published over the past few weeks in response to the Francis Report on the Mid-Staffordshire NHS Foundation Trust Public Inquiry[1] and a third report has addressed the issue of failing hospitals in England. The UK government's initial response to the Francis report, *Patients First and Foremost*[2] and the report from Don Berwick and the National Advisory Group, *Improving the Safety of Patients in England*[3] both seek to address the key quality issues for all health systems of safety, effectiveness and experience,[4] and both emphasise a system-wide response, but they take different approaches to addressing these issues.

The government's response focuses on regulation, measurement, monitoring and accountability to prevent, detect and address problems promptly; there is a focus on training and revalidation of nurses and healthcare assistants, and continued support for leadership training and executive boards. There is recognition that the regulatory and inspection system needs to be improved, that data need to be used more effectively, and that transparency and openness should be supported.

Despite references to 'the system' and 'working together', the report lacks a coherent approach that addresses the whole system from patients and their relatives to government and the framework in which they operate. The report's approach to education and training is somewhat narrowly focused on training, supervision and regulation of healthcare assistants and nurses.

The Berwick Report is more succinct but is clearer on what needs to be done across the whole system. Its overarching aim that 'the NHS should continually and forever reduce patient harm by embracing wholeheartedly an ethic of learning' focuses on safety, but the subsequent recommendations also address the domains of patient experience and clinical effectiveness. The recommendations are the distillation of many decades' experience of research into quality and safety by an expert group of scientists, patients and managers which formulates a set of principles and actions for improving quality and safety in the NHS.

The Berwick Report explicitly recognises that the health service is a system, and so each aim is translated into recommendations addressed to various actors in the system from patients, healthcare workers, health organisations and regulators to the government. There is also recognition that many of the elements of an excellent system are in place already – and that what is less evident now is how these elements should co-operate and interact better to provide a safer health system.

The areas that are focused on by Berwick are critically important for safety and quality:

- leaders and managers should place quality and safety of care at the forefront of what they do
- patients and carers should be present, powerful and involved at all levels of healthcare organisations
- there should be sufficient staff to provide safe care
- all healthcare and management staff should have training in quality and patient safety science as part of initial and lifelong education to enable the NHS to become a learning organisation capable of change
- non-identifiable data should be shared openly to support safety and improvement, and the patient and carer voice should be seen as an essential asset in monitoring
- supervisory and regulatory systems should be simple, clear and responsive with clear lines of accountability
- recourse to criminal sanctions should be extremely rare but should function primarily as a deterrent to wilful or reckless neglect or mistreatment.

Finally, the Keogh *Review into the Quality of Care and Treatment Provided by 14 Hospital Trusts in England*[5] picks up similar themes:

- focusing on improvement (reducing avoidable deaths); accessing and using data for quality improvement
- involving patients, carers and members of the public as vital and equal partners in design of services

- involving patients and clinicians as active participants in regulatory inspections
- eliminating professional, academic and managerial isolation; improving nurse staffing levels and skill mix
- educating specialists in training to be clinical leaders
- supporting staff to be happy and engaged because of the positive effect on patient outcomes.

These reports and their recommendations together provide an agenda for action and learning for the NHS now and for the foreseeable future. They provide a challenge for organisations to change their culture and leadership to focus on quality, for healthcare staff to skill themselves in quality improvement and safety science supported by educational provision from higher education, and for patients and carers to have a stronger voice in the health service than ever before.

REFERENCES

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4 Darzi of Denham AD. *High Quality Care for All: NHS Next Stage Review final report*. The Stationery Office: London, 2008.
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PEER REVIEW

Commissioned; not externally peer reviewed.

CONFLICTS OF INTEREST

None declared.

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