Learning from failings in healthcare: a challenge for all healthcare systems

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Might Mid Staffs be a turning point?

The most important single change in the NHS in response to this report would be for it to become more than ever before a system devoted to continual learning and improvement of patient care, top to bottom, end to end. 1

Reactions to significant and public failings in healthcare in the UK, and no doubt elsewhere in the world, trigger forensic inquiries. The aim, after finding out what went wrong, is to draw out lessons with the aim of ‘it’ never happening again. Each inquiry, whether small and internal or large and statutory, publishes a report with recommendations. These reports make difficult reading for anyone working in healthcare. For although the context and clinical details are never quite the same, they point to similar and familiar failures. The latest public failing in the UK has triggered not one but two inquiries and three reports: a report followed each inquiry with a third from an expert group, chaired by Professor Don Berwick, charged with taking the lessons from this latest failing and specifying what changes are needed to make the National Health Service (NHS) a safer health system. Will this third report, written to, and for, everyone in the NHS, make a lasting difference?

The context for the Berwick report is the care provided at Mid Staffordshire Trust, a district hospital in the English West Midlands. Concerns about standards and the safety of care, and a higher than expected death rate, alerted the regulator, the Health Care Commission, which in 2009 investigated this hospital and published a report very critical of standards of care. There followed reports by the Department of Health and, later in 2009, the Secretary of State for Health commissioned an independent inquiry chaired by Robert Francis QC, which reported in 2010.2 But continued widespread public disquiet and anger, reflected through pressure groups and media coverage, about the extent of harm to patients at this hospital prompted a public independent inquiry also chaired by Robert Francis. Building on the first inquiry, the second looked beyond the hospital to the wider healthcare system and considered, for example, the effectiveness of the supervisory and regulatory organisations. The objectives of this second report included identifying lessons that would enable the NHS to recognise failing hospitals sooner. The final report published in 2013—Analysis of Evidence and Lessons Learned—has 290 recommendations that reach into most parts of the NHS.3

Both Francis reports reflect a tragedy affecting many people played out slowly over several years—replays have since provoked a background anxiety in the NHS. Some patients died when they should have lived; many more were harmed or received appalling care; and many patients and their relatives suffered. The inquiry concluded that the failings started at the top with a board which had somehow allowed a negative culture, tolerant of poor care, to pervade the hospital, and it is clear that many of the ‘checks and balances’ that should have prevented failings (including organisations with oversight of the hospital) simply did not work. The temptation in the face of such failings is to seek whom to blame. But the inquiry is clear: this was essentially a system failure. The government, determined that there will not be another ‘Mid Staffs’, responded robustly and has, for example, introduced a chief inspector of hospitals and a new rating system for hospitals.

For Francis the key is in the culture of a hospital. Patients looked after by people working in a culture of openness and honesty that fosters good, well-functioning teams will receive much better and safer care than people, such as many of those cared for at Mid Staffordshire, whose treatment depends on staff who are disengaged and working in an atmosphere of fear and isolation. Changing the culture of any organisation is tough. New and ingenious strategies and well worked through project plans have their place but they are unlikely to make an impact on the culture of an organisation: ‘culture eats strategy for breakfast’.4 Pressuring people to ‘do better’ or promoting change through fear or regulation at best will produce workarounds or gaming and is very unlikely to result in lasting commitment to change.

Just publishing the findings of inquiries seems unlikely to make a difference: we have four decades of experience of the apparent lack of impact of such reports. In 2002 Walsh and Higgins compared the reports of over 50 major inquiries into failings in the NHS from 1972 to 2001 and found that “Many inquiry reports highlight similar sorts of failings, suggesting that lessons are not always learnt. Often these failings are organisational and cultural, and the necessary changes are not likely to happen simply because they are prescribed in a report”.5 They identified five common themes (box 1).

This time, in a change from usual practice, while public and media interest remained fresh and raw and those in the health service were still sensitised to the possibility that there might be ‘other Mid-Staffs’, the government asked Professor Don Berwick to chair a National Advisory Group on the Safety of Patients in England and to set out recommendations and specify the changes needed for the NHS to deliver consistently better and safer care. Free from the need to collect and collate evidence from a specific place and event, the Berwick Committee, made up of academics and experts in organisational theory, quality improvement, safety and systems, used the tragedy of ‘Mid Staffs’ and Francis’...
Box 2 Berwick Committee’s 10 recommendations

► The NHS should continually and forever reduce patient harm by embracing wholeheartedly an ethic of learning.
► All leaders concerned with NHS healthcare—political, regulatory, governance, executive, clinical and advocacy—should 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.
► Patients and their carers should be present, powerful and involved at all levels of healthcare organisations from wards to the boards of trusts.
► Government, Health Education England and NHS England should ensure that sufficient staff are available to meet the NHS’s needs now and in the future. Healthcare organisations should ensure that staff are present in appropriate numbers to provide safe care at all times and are well supported.
► Mastery of quality and patient safety sciences and practices should be part of initial preparation and lifelong education of all healthcare professionals, including managers and executives.
► The NHS should become a learning organisation. Its leaders should create and support the capability for learning, and therefore change, at scale, within the NHS.
► Transparency should be complete, timely and unequivocal. All data on quality and safety, whether assembled by government, organisations, or professional societies, should be shared in a timely fashion with all parties who want it, including, in accessible form, with the public.
► All organisations should seek out the patient and carer voice as an essential asset in monitoring the safety and quality of care.
► 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. All incentives should point in the same direction.
► We should support responsive regulation of organisations, with 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.

Box 3 Berwick Committee’s four principles for the NHS as a learning organisation

► Place the quality of patient care, especially patient safety, above all other aims.
► Engage, empower and hear patients and carers at all times.
► Foster whole-heartedly the growth and development of all staff, including their ability and support to improve the processes in the area in which they work.
► Embrace transparency unequivocally and everywhere, in the service of accountability, trust, and the growth of knowledge.

The result is a report with a difference. Written simply, straightforwardly and concisely it outlines 10 recommendations and includes four main principles to guide everyone trying to build an even better ‘learning NHS’ (boxes 2 and 3). In a letter to the people of England, it outlines the role of patients and a set of actions for patients and carers. Reaching out in the role of patients and a set of actions for patients and carers. Reaching out in the role of patients and a set of actions for patients and carers. Reaching out in the role of patients and a set of actions for patients and carers.
it is to value team learning as much as the individual pursuit of knowledge and skills. Responsibility for both individual patients and for making the system of care work for patients lies with everyone who works in healthcare. A key leadership task is to make sure that this balance is right. One of the difficulties in putting the Berwick recommendations into action is that many of today’s dedicated senior practitioners and those responsible for training curriculums, who have massive influence on how we work and learn, might not have had the opportunity to train in what the Berwick report describes as ‘Mastery of quality and safety sciences and practices’. Implicitly, the Berwick report challenges traditional hierarchies: collaboration through networks is what is needed to make a real difference and to ensure that the NHS is a learning organisation and ‘safe, effective and patient centred’. Functional teams who work well together, and learn together, will be able collaborate and work with other effective teams to form networks to become an ever evolving and improving system of care.

In the end most improvements in care require organisational changes, which means changing the way in which we work together. This is not easily achieved within rigid hierarchies. The daily question for each team: ‘How can we do better?’ can only be answered by ‘Is there a better way of working together that will improve how we deliver care for our patients?’ This can only be achieved if we are aware of, and take responsibility for, how we work together—and these responsibilities lie most heavily on those who have senior positions in the health system. The Berwick Committee writes, “Make sure that pride and joy in work, not fear, infuse the work of the NHS”. The people who work in health systems matter and they must be cared for so that they can care properly for their patients. Without this how can the NHS ensure both that the core things—the right treatment for the right patient at the right time—happen and that the organisational behaviours that bind these essentials together and attention to important personal details of care are also not neglected?

Most reports into failings end up as failures. There is no magic bullet that will improve care, and ‘shouting’ at staff through such reports does not work. But by emphasising the importance of learning the Berwick report just might help the NHS become safer. An urgent task for all leaders within the NHS is to ensure that learning becomes part of the fabric of the whole system—‘top to bottom, end to end’: just what needs to be done is all set out in the Berwick report. Teams whose leaders understand the task, can start this work today: there will be no starting gun. Ensuring good quality and safe care in the end is down to them and how they learn and support their patients and each other, and not to the secretary of state for health and his or her directives. And though written for the NHS, the Berwick report’s uncompromising challenges are relevant to all healthcare systems.

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