A promise to learn- a commitment to act. Improving the Safety of Patients in England
The Berwick report - Summary

Review- background, methodology and aims

Berwick, a paediatric cardiologist, professor in Health Policy, and a world leader in patient safety, was asked by the Prime Minister to carry out a review on patient safety following publication of the Francis Report into the breakdown of care at Mid Staffordshire Hospitals. An advisory group of experts in minimising patient harm sat between March–July 2013, meeting mostly bi-weekly and virtually, with working parties established for 9 key themes. The advisory group sought to develop a small and cogent set of principles and actions that would move the NHS to better care, focusing on the following themes:-

1. Patient safety problems exist throughout the NHS-patient safety should be strengthened
2. NHS staff are not to blame- the vast majority do a good job
3. Incorrect priorities do harm- ie focus on hitting targets and cutting costs, not on the patient
4. Warning signals abounded and were not heard or acted on- explained away; complaints ignored
5. Responsibility is diffuse, so it becomes no-one problem – no-one is in charge (of safety) – spread across organisations
6. Improvement needs a system of support – most important single change would be to become a system devoted to continual learning and improvement of patient care
7. Fear is toxic to both safety and improvement ('better not to know')

The report does not claim to be comprehensive, but to complement other reports and studies, notably the Francis report, and specifically states that the advisory group endorses the recommendations within the Keogh report.

Emergent themes

The advisory group considered definitions of quality and patient safety; and concluded that the dimension emerging most strongly is that of 'Safety'. In addition, the report take time to note what is good, and specifically states that the NHS is not unsound to its core. Also noted that the Francis report recommended loads of new regulation which does have a role/place; and that the Keogh study suggests that clear and prompt responses to warnings needed to ensure quality. However, quality assurance and continual improvement can't be resolved by regulation based on technically specific standards. The report makes the following key points, which are threaded throughout the document:-

- **Culture will trump rules standards and strategies – building a safer NHS depends far more on major cultural change than on any new regulatory regime.**
- **The single most important change is for the NHS to become a system devoted to continual learning and improvement of patient care**
- **The culture of learning** cannot come from regulation, but from "countless, consistent and repeated" messages to staff so that goals and incentives are clear and in patients' best interests
- **There is no single measure for safety**

The report has produced four main principles, sub set of principles for 6 different organisation types, and actions – under the 9 headings – hence various summaries and reports focus on different numbers and sets of priorities and actions

Recommendations- bold text lifted from report

1. **overarching goal**
    - **the NHS should always reduce patient harm by embracing an ethic of learning**

    Protecting patients from harm should not be over-ridden by targets - all are urged to live the values in the constitution. Culture change is needed across the whole system in respect of goals and incentives.
    - No specific actions or duties are given for this section

2. **Leadership**
    - **All leaders should hold quality and safety at the top of the priorities**

    What this means
    - *Majority of actions are for Govt and leadership bodies, & NHSE*

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- *All NHS funded organisations have a duty to identify risks, and to develop the skills to do so*
- *All NHS funded organisations should address poor teamwork and poor individual practice*

The following are not specified as actions for commissioners, but may well apply. Leaders should:-

- Expect transparency in data from providers, welcoming warnings and using the data to support continual improvement
- Move from focus on costs and targets to focus on the patient
- Hear the patient voice at every level (including whispers

3. **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.**
     Notes that this is more than involving people in a discussion about services, but is about listening to all voices, even the whispers, it's also about people being involved in their own care. Patient voice should be heard at all levels.
     What this means for the CCG
     - States specifically that the patient voice should be head during commissioning.
     - Commissioners also need assurance that providers are listening to the patient voice.
     - NB does say that 'CCGs and providers should ensure a specific, named and recognised clinician known to the patient is responsible for the coordination of the care for every patient at every phase of treatment regardless of setting – how can CCGs do this?

     All organisations
       - Need to ensure people are involved in their care and have the chance to share their concerns.
       - Complaints should be used to provide quality and safety data
       - Should foster a pervasive culture that welcomes engagement

4. **Staff**
   - **Sufficient staff now and in the future (national); enough staff present in healthcare settings to ensure safe care**
     What this means
       - *Actions targeted at provider organisations*
       - *There is a recommendation that NICE produce guidance on staffing ratios and patterns*

5. **Training and capacity building**
   - **All healthcare professionals should take up lifelong education to master quality and patient safety sciences**
   - **NHS should be a learning organisation, with leaders creating and supporting capability for learning and therefore change**

   What this means for the CCG
   - *Most of the points are aimed at NHS England and education providers, none for commissioners*
   - *two are for 'all NHS organisations'*
     - *providers will need to have a properly resourced capability programme in place within 12 months*
     - *every NHS organisation should participate in one + collaborative improvement network*

6. **Measurement and transparency**
   - **Transparency should be complete, unequivocal and timely, (relevant) data accessible and shared with the public**
   - **Patient and carers voice sought out to help monitor quality and safety**
     Comprehensive list of indicative data types that should be actively interrogated, but notes that staff survey data should not be used as a performance management tool. Notes that most organisations have little capacity to analyse, etc, and that local fine grained analysis is needed to show ward or service level variation

   What this means for the CCG

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-CCGs should share all data on quality and safety (maintaining confidentiality)
- CCGs should include patient voice as an essential resource for monitoring and improving
*- **Commissioners should increase funding for NHS organisation to analyse and effectively use safety and quality information***
-Organisations should use mortality figures as a 'smoke detector' pending any better metrics being developed
-all organisations should collect/analyse/respond to 'early warning' indicators and quality metrics.

7. **Structures**
   - **Supervisory and regulatory systems should be simple and clear, avoiding diffusion of responsibility; with incentives pointing in the same direction.**

   What this means
   - *Most actions are for Govt; NHSE, CQC and include (NHSE) redesign of patient safety alert system; seamless co-operation*
   - *All organisation to streamline requests for info (**commissioners included)***
   - *CQC to develop Francis' fundamental standards'*
   - *Govt to review structures and regulatory system by end 2017*
8. **Enforcement**
   - **Support responsive regulation of organisations, with a hierarchy or responses, using criminal sanctions as rare/deterrent; and that errors not be criminalised**

   What this means
   - *Recommends that wilful or reckless neglect of patents be on a par with offence to vulnerable people under the Mental Capacity Act*
   - *Action s are for Government, CQC, providers and regulators*
   - *Recommend that it should be an offence for healthcare organisation to withhold or obstruct information to a commissioner*
   - *Recommends that info be given to patients and carers about serious incidents, but does not recommend 'duty of candour' where every error or near miss is reported.*

9. **Moving forward**

   This section breaks down actions for different stakeholders; but does not list CCGs or commissioners separately. (NHS organisation leaders and boards are possibly the closest). The points here are (summarised)
   - Listen to and involve patients
   - Monitor quality and safety
   - Respond to alerts and complaints
   - Embrace complete transparency
   - Train and support staff to improve care
   - Join multi- agency collaborative
   - Use evidence based tools to ensure adequate staffing levels

ENDS

Helen Wyatt; Aug 2013.