A PROMISE TO LEARN – A COMMITMENT TO ACT: IMPROVING THE SAFETY OF PATIENTS IN ENGLAND

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The Problems

1. Patient safety problems exist throughout the NHS.
2. NHS staff are not to blame.
3. Incorrect priorities do damage.
4. Warning signals abounded and were not heeded.
5. Responsibility is diffused and therefore not clearly owned.
6. Improvement requires a system of support.
7. Fear is toxic to both safety and improvement.
The Solutions

1. Recognise with clarity and courage the need for **wide systemic change**.

2. **Abandon blame** as a tool.

3. Reassert the primacy of **working with patients and carers** to set and achieve health care goals.

4. Use quantitative targets with **caution**.

5. Recognise that **transparency** is essential.

6. Ensure **responsibility** for functions related to safety & improvement are vested clearly and simply.

7. Give the people of the NHS career-long help to **learn, master and apply** modern methods for quality control, quality improvement and quality planning.

8. Make sure **pride and joy** in work, not fear, infuse the NHS.
Culture will trump rules, standards, and control strategies every single time.

A safer NHS will depend far more on major cultural change than on a new regulatory regime.
Quality for the NHS

• **Safety**: Avoiding harm from the care that is intended to help

• **Effectiveness**: Aligning care with science and ensuring efficiency

• **Patient-experience**: Including patient-centeredness, timeliness and equity
Recommendation Categories

I. The Overarching Goal
II. Leadership
III. Patient and Public Involvement
IV. Staff
V. Training and Capacity-Building
VI. Measurement and Transparency
VII. Structures
VIII. Enforcement
IX. Moving Forward
Recommendations

1. The NHS should continually and forever reduce patient harm by embracing wholeheartedly an ethic of learning.

2. All leaders should place quality of care and patient safety at the top of their priorities for investment, inquiry, improvement, regular reporting, encouragement and support.

3. Patients and their carers should be present, powerful and involved at all levels.

4. Government, Health Education England and NHS England should assure that sufficient staff are available.
5. Mastery of quality and patient safety sciences and practices should be part of initial preparation and lifelong education of all health care professionals.

6. The NHS should become a learning organisation.

7. Transparency should be complete, timely, and unequivocal.

8. All organisations should seek out the patient and carer voice as an essential asset in monitoring the safety and quality of care.
9. 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.

10. We 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 willful or reckless neglect or mistreatment.
I. The Overarching Goal

- The NHS should continually and forever reduce patient harm by embracing wholeheartedly an ethic of learning.
II. Leadership

• All leaders concerned with NHS healthcare – political, regulatory, governance, executive, clinical and advocacy – should place **quality of care** and **patient safety** at the top of their priorities for investment, inquiry, improvement, regular reporting, encouragement and support.

• Who are the leaders?
  • All staff and leaders of NHS-funded organisations
  • All leaders and managers of NHS-funded organisations
  • NHS England
  • Leadership bodies of NHS-funded organisations
  • Prime Minister and Government
  • Local Government Association
III. 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.

Patients and carers should seek to establish relationships with healthcare staff and know their names. Patients and carers should seek to build constructive relationships with their caregivers and develop mutual respect, honesty and trust.

Patients and carers should try to share their histories, family situations, needs and hopes to help staff build true and effective partnerships during their care. They should aim as far as possible, to become co-producers of their care.

Patients should share their goals, participate in creating plans for their care, engage their families and bring carers or relatives to visit, particularly during ward rounds and other clinical meetings.

Patients and their carers should alert those working in healthcare when care is not meeting their needs or when they see a practice that they feel is not safe.

Patients should, when they wish, advise leaders and managers by offering their expert advice on how things are going, on ways to improve, and on how systems work best to meet the needs of patients. This may mean giving time to attend meetings, participating in sessions to learn how the health care system works, learning the “inside” language that they will encounter, and learning to speak effectively to “authority”.

IV. Staff

- Government, Health Education England and NHS England should assure 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**.
# IV. Staff

## Actions for Staff

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<td><strong>Place the needs of patients, families and carers at the centre of all your work, treating them with courtesy and respect, and intervene if you see others who do not.</strong></td>
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<td><strong>Be a quality inspector, never knowingly passing on a defect, error or risk to a colleague or patient, putting things right where you can, and reporting everything, especially where you need help to put it right.</strong></td>
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<td><strong>Be willing to acknowledge and be open when something has gone wrong and make timely apologies and reparation where appropriate.</strong></td>
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<td><strong>Appreciate that your responsibility is not only to your patients but also to help continuously improve the healthcare system in collaboration with others.</strong></td>
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<td><strong>Treat your colleagues with respect and courtesy and seek to create supportive teams with common goals.</strong></td>
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<td><strong>Commit to learning about patient safety as a core professional responsibility and develop your own ability to detect problems.</strong></td>
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<td><strong>Be willing to speak up to leaders when you believe that a lack of skills, knowledge or resources places patients at risk of harm, and be willing to listen to others when they identify these risks.</strong></td>
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<td><strong>Celebrate and take pride in improvements to patient care.</strong></td>
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V. Training and Capacity-Building

- Mastery of quality and patient safety sciences and practices should be part of initial preparation and lifelong education of all health care 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.
Suggested Improvement Skills

- Setting goals and measures
- Identifying problems
- Mapping processes
- Testing change
- Simple waste reduction
- Simple standardisation
- Team behaviours

- Setting goals and measures
- Identifying problems
- Mapping processes
- Sequencing tests of change
- Simple understanding variation
- Implementation and spread
- Simple waste reduction and standardisation
- Leads microsystem while understanding systems thinking

- Setting direction and big goals
- Execution leadership
- Portfolio selection and management
- Oversight of improvement
- Being a champion and sponsor
- Understanding variation to lead

- Analysis, prioritisation of portfolios
- Deep statistical process control
- Deep improvement methods
- Leadership team advisory, re. portfolio selection, process
- Effective plans for implementation and spread
VI. Measurement and Transparency

• Transparency should be complete, timely and unequivocal. All non-personal 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.
Indicators that should be used to assess safety improvement and variation

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<td>The perspective of patients and their families</td>
<td>Measures of harm</td>
<td>Measures of the reliability of critical safety processes</td>
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<td>Information on practices that encourage the monitoring of safety</td>
<td>Information on the capacity to anticipate safety problems</td>
<td>Information on the capacity to respond to and learn from safety information</td>
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<td>Data on staff attitudes, awareness and feedback</td>
<td>Mortality rate indicators</td>
<td>Staffing levels</td>
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<td>Data on fundamental standards</td>
<td>Incident reports</td>
<td>Incident reporting levels</td>
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VII. Structures

- 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.
VIII. Enforcement

• We 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.
IX. Moving Forward

1. **Place** the quality of patient care, especially patient safety, above all other aims.

2. **Engage, empower, and hear** patients and carers throughout the entire system and at all times.

3. **Foster** whole-heartedly the growth and development of all staff, including their ability and support to improve the processes in which they work.

4. **Embrace** transparency unequivocally and everywhere, in the service of accountability, trust, and the growth of knowledge.
The NHS in England can become the **safest health care system in the world.**

That will require unified **will, optimism, investment**, and change.

**Everyone** can and should help.

And, it will require a culture firmly rooted in **continual improvement.**

Rules, standards, regulations, and enforcement have a place in the pursuit of quality, but they pale in potential compared to the **power of pervasive and constant learning.**
For Government and NHS England Leaders:

- State and restate the primacy of safety and quality as aims of the NHS: Assure prompt response to and investigation of early warning signals of serious problems, and, when needed, assure remedy.
- Support investment in the improvement capability of the NHS.
- Lead with a vision. Avoid the rhetoric of blame. Rely on pride, not fear.
- Reduce the complexity of the regulatory system, and insist on total cooperation among regulators. If they do not cooperate, restructure them.
For NHS Organisation Leaders and Boards:

- Listen to and involve patients and carers in every organisational process and at every step in their care.
- Monitor the quality and safety of care constantly, including variation within the organisation.
- Respond directly, openly, faithfully, and rapidly to safety alerts, early warning systems, and complaints from patients and staff. Welcome all of these.
- Embrace complete transparency.
- Train and support all staff all the time to improve the processes of care.
- Join multi-organisational collaboratives – networks – in which teams can learn from and teach each other.
- Use evidence-based tools to ensure adequate staffing levels.
For System Regulators:

- Simplify, clarify, and align your requests and demands from the care system, to reduce waste and allow them to focus on the most important aims.
- Cooperate fully and seamlessly with each other.
For Professional Regulators and Educators:

• Assure the capacity and involvement of professionals as participants, teammates, and leaders in the continual improvement of the systems of care in which they work.

• Embrace complete transparency.
For NHS Staff and Clinicians:

- Participate actively in the improvement of systems of care.
- Acquire the skills to do so.
- Speak up when things go wrong.
- Involve patients as active partners and co-producers in their own care.
For Patients and Carers:

- As far as you are able, become active partners in your healthcare and always expect to be treated as such by those providing your healthcare.
- Speak up about what you see – right and wrong. You have extraordinarily valuable information on the basis of which to make the NHS better.