Is patient safety in the NHS fundamentally broken?

John Tingle, Associate Professor, Birmingham Law School, University of Birmingham, discusses the state of patient safety in the NHS and several key reports

New Secretary of State for Health, and Social Care Wes Streeting has described the NHS as being broken (Department of Health and Social Care (DHSC), 2024a). This is a controversial and bold statement and can be seen to strike at the heart of NHS patient safety culture development efforts. In an interview for *The Guardian (*Elgot and Campbell, 2024), he said:

> **'I'm extremely anxious about maternity services. And what frightens me is the issues we've seen raised in relation to Nottingham and Kent – I think [they] are a risk factor right across the NHS, and it's one of the big reasons why we are losing midwives faster than we can recruit them in some cases.'**

This illustrates that the Health Secretary is acutely aware that there are major NHS patient safety problems that urgently need fixing. He also commented on Martha's Rule, saying that the NHS should go further, and on the Care Quality Commission (CQC), among other matters (Elgot and Campbell, 2024).

Is NHS patient safety broken?

A fundamental question to ask is whether NHS patient safety, policy and practices are broken and, if so, to what extent? How far can we stretch the broken label across NHS healthcare regulation, governance and patient safety? Is it fundamentally broken?

In *The Guardian* interview (Elgot and Campbell, 2024), Streeting responded to questions about the CQC:

> **'…he agreed that the CQC was losing the confidence of concerned NHS staff and said they were begging for a stricter inspection regime.'**

Events are moving quickly and, after receiving the early findings of an independent interim review on the CQC, the Health Secretary said that it is unfit for purpose and pledged to review all patient safety organisations. Around the time of its formation, the CQC was heralded in the Darzi report (Department of Health (DH), 2008), so it will be interesting to see what the 2024 review, due to be published in September, makes of NHS and CQC performance.

In terms of NHS patient safety, I would say it is not fundamentally broken, but it does need a lot of help to improve. Significant reform is needed: for example, many patient safety functions are duplicated between NHS organisations, within what is a fairly complex and disjointed system.

However, over the years there have been good NHS patient safety improvements, which need to be factored into any reform equation. We have a good knowledge of patient safety problems, causes and solutions. We know there is a gap between patient safety policy, learning and what happens on the ground. We have the NHS Patient Safety Strategy, NHS Patient Safety Syllabus, Patient Safety Incident Response Framework (PSIRF), Duty of Candour, Martha's Rule and more. These are good initiatives, but they have been overshadowed by patient safety crises, such as the maternity and Mid Staffordshire.

What we can say

Fundamental NHS patient safety problems stubbornly persist, despite good patient safety policies being in place, which has been the case for some time. I have previously said that the NHS is patently poor in some quarters of learning the patient safety lessons from past crises and in changing practices.

We need to try harder, collectively as an NHS, to improve and work towards developing a proper patient safety culture. We have the tools and the policies to do this, which we can refine and add to. This would include, for example, formal regulation of NHS managers. The subject of NHS whistleblowers and the regulation management of trusts is also a vexed one.

Darzi review

As already mentioned, Lord Darzi is to lead an immediate and independent investigation of the NHS:

> **'It will have a particular focus on assessing patient access to healthcare, the quality of healthcare … and the overall performance of the health system.'**
>
> *DHSC, 2024b*

The report is likely to hold few surprises. The problems of healthcare quality and performance have been so well documented that most people already know the answers, particularly in relation to NHS patient safety culture development.

It will be interesting to see whether much has changed in 16 years in terms of patient safety since the publication of Darzi's earlier report, *High Quality Care for All* (DH, 2008). Are the problems identified back then still largely with us? In terms of language, the 2008 report set an inspirational tone, and was clear and informed.

Darzi 2008 and patient safety

In terms of patient safety, we saw in Darzi (DH, 2008) the launch of the NHS Constitution for England and Never Events, both now the subject of review and consultation announced by the previous government. The CQC was discussed, as was what it was hoped the new organisation would achieve. The groundwork for some key components of our current health regulatory and governance, and patient safety system, was laid out in this seminal report. Reading it today we can still relate to the issues identified then, such as the critical importance of patient safety:

> **'…The first dimension of quality must be that we do no harm to patients. This means ensuring the environment is safe and clean, reducing avoidable harm such as excessive drug errors or rates of healthcare associated infections.'**
>
> *DH, 2008:47*

Reforms, the report stated, had improved quality in terms of patient safety and effectiveness of care, but said that progress had been 'patchy, particularly on patient experience'. Going forward to the new report, I hope this will contrast patient safety, health quality findings with those highlighted in the 2008 report. There is also a significant patient safety organisation reform trajectory created by the new government and the forthcoming review of patient safety organisations.

NHS patient safety culture development

As stated above, I work on the premise that patient safety in the NHS is not fundamentally broken, but that it is in urgent need of changes to make it better and more fit for purpose. Our NHS health regulation, governance, patient safety system generally works, but I would argue that all too frequently it stumbles and avoidable patient injuries occur. Generally works, however, is not good enough.

I discuss below some of NHS patient safety culture development, tools and reports showing that we have the knowledge, ability and potential to develop an effective NHS patient safety culture but that we all need to try much harder, to make it more than well-meaning aspiration.

NHS England's practical guide

The document, *Improving Patient Safety Culture: A Practical Guide* is described as a 'toolkit' to help create a positive NHS safety culture, and provides theories to underpin this (NHS England, 2023). Sections include: teamwork and communication, just and restorative culture, psychological safety, promoting diversity and inclusive behaviours, and civility. These are all key prerequisites to develop an effective patient safety culture, and their lack can seriously inhibit the development of a good patient safety culture. They can also be seen as underpinning factors that have led to patient safety errors, as highlighted in several national patient safety investigation reports. If we can properly understand these factors, and use them to inform practice, then we are on the road to a safer NHS.

The guide (NHS England, 2023) has links to further reports, discussions and best practice case studies and it provides useful patient safety culture development building blocks.

NHS Resolution charter

The NHS Resolution (2023) report, *Being Fair 2*, highlights the need to address matters of incivility, harassment, bullying, the need for fair processes for managing concerns in the NHS. That developing an open, fair, and inclusive work environment is fundamental to good culture development and patient safety. NHS Resolution (2023) presents a deep dive into these issues.

It can be seen from several past patient safety investigation reports that failures can result in severe patient harm. Sections cover the scale of the problem, insights from stress-related claims, improving workplace culture, and so on. In the section on insights from stress related-claims it is stated:

> **'A lack of support, difficult working relationships and poor behaviours are the most frequently occurring themes in claims that concern work-related stress'**
>
> *NHS Resolution, 2023:11*

In section 10 (NHS Resolution, 2023) there is included a Just and Learning Culture Charter, which organisations are invited to adopt. Ten components, attributes of a learning organisation are stated in the charter: Accountable, Leadership, Wellbeing, Compassion, Inclusive, Respectful, Candour, Learning, Best practice, and Evaluation.

The charter goes into more detail on each component, which are well crafted and offer excellent, clear advice. An example is the component 'Candour', which includes the following statement:

> **'… clinical incidents have a real and deep impact on people's lives. Patients … have a right to explanations, to receive apologies and … assurances and/or financial compensation for injuries caused where appropriate.'**

Safety management systems

The Health Services Safety Investigations Body (HSSIB) (2023) introduces safety management systems (SMSs) and how these are used in other safety critical industries and could be used in health care. For example:

> **'An SMS is a proactive and integrated approach to managing safety. It sets out the necessary organisational structures and accountabilities and will continuously be improved. It requires safety management to be integrated into an organisation's day-to-day activities.'**

There is a discussion of SMS development in health care (HSSIB, 2023), as well as safety accountability frameworks across the sector and safety maturity assessments. The report also looks at what future work could look like to explore the SMS approach to health care, and includes a link to an SMS explainer video. It also makes safety recommendations to both NHS England and the CQC using the SMS approach.

Conclusion

Is setting out its NHS improvement stall the new government has made some hard-hitting pronouncements on identified problems and a future approach. The 2024 Darzi report will be awaited eagerly and will hopefully identify the many patient problems that stubbornly beset the NHS, and create an important agenda and trajectory for change.

The report's expected findings are, however, unlikely to come as a revelation, as many patient safety problems have been well known for some time, such as those relating to patient safety organisations, and CQC's fitness for purpose.

I would argue that, taking into account all of the above, the NHS's health regulatory, governance and patient safety system cannot be termed as being fundamentally broken. It has some good, well-crafted patient safety policies and tools, some of which are discussed above. However, reform is needed on a significant scale. I note that positive steps have been taken to develop an NHS patient safety culture, but the pace is much too slow. It must be accelerated because well-chronicled, unacceptable practices cause serious patient harm all too frequently. **BJN**

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