Care Quality Commission

Healthcare: Thinking like a high risk industry

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GS1 UK Healthcare Conference
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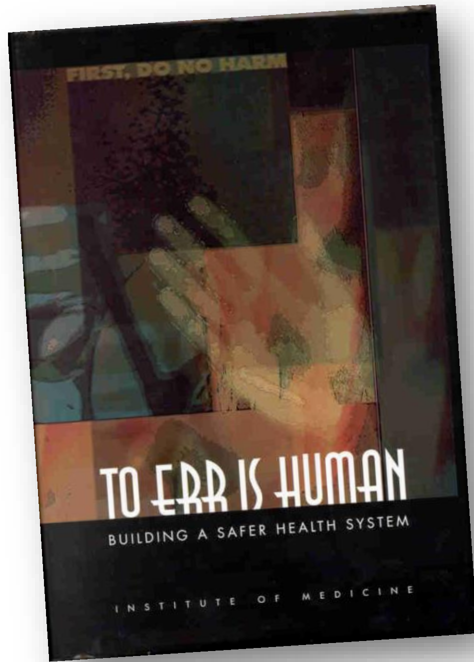
20 years on…



…medical errors do not result from individual recklessness or the actions of a particular group.

…errors are caused by faulty systems, processes, and conditions that lead people to make mistakes or fail to prevent them.

…mistakes can best be prevented by designing the health system at all levels to make it safer – to make it harder for people to do something wrong and easier for them to do it right.

…when an error occurs, blaming an individual does little to make the system safer and prevent someone else from committing the same error.

6 years on…

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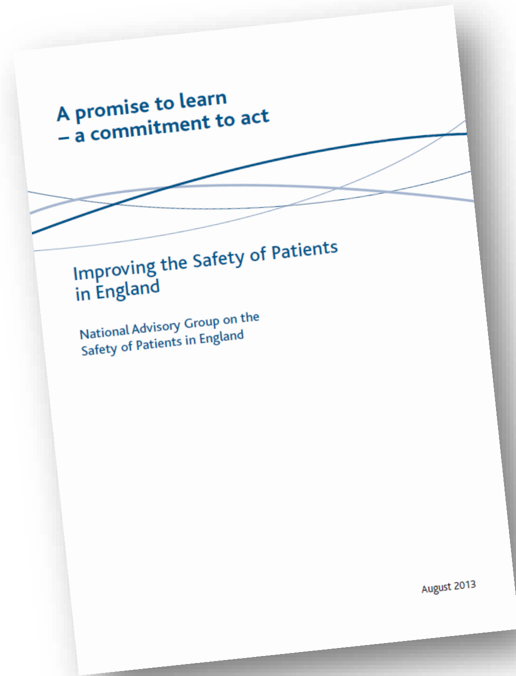

- The NHS should become a learning organisation.
- Its leaders should create and support the capability for learning, and therefore change, at scale, within the NHS.
- When people find themselves working in a culture that avoids a predisposition to blame…they can avoid the fear, opacity, and denial that will almost inevitably lead to harm.

CQC report 2017

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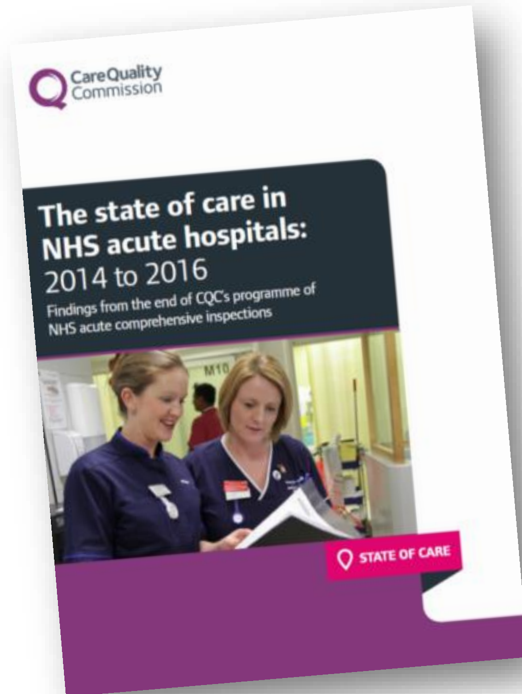

"While hospitals recognise patient safety as their top priority, this is frequently not translated into an effective and consistent safety culture."

"In an effective safety culture, safety is everyone's responsibility…all staff have a duty to protect patients from harm. This includes reporting patient safety incidents and being actively involved in learning from them to drive continuous improvements in safety."

Driving improvement

- Collaborative, distributed **Leadership**
- **Cultural change** – engaging and empowering staff
- **Openness** to learning and improving safety – **transparency**
- Effective **Governance**
- **Real involvement** of patient and public
- Focus on continuous **quality improvement** driven from frontline

eQuality
nmission

State of Care 2018

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Acute services

- 60% rated good
- 6% rated outstanding
- 31% rated requires improvement
- 3% rated inadequate

Mental Health services

- 71% rated good
- 8% rated outstanding
- 20% rated requires improvement
- 1% rated inadequate

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But safety is still our biggest concern:

- 40% of acute services and 37% of mental health services rated requires improvement for safety
- 3% are rated inadequate for safety

468 never events reported in 2017/18

203 wrong site surgery incidents (for example, ovaries removed in error during a hysterectomy, wrong eye injection, wrong level spinal surgery)

112 retained foreign body post procedures (for example, guide wires, surgical swab, needle)

26 misplaced naso- or orogastric tubes

35 medication administration errors (including, administering medication by the wrong route, overdose of methotrexate or insulin, and mis-selection of strong potassium solution).

64 wrong implant / prosthesis (for example, hip, knee, lens)

NHS staff do a remarkable job to keep patients safe, but…

…despite their best efforts, never events continue to happen.

- Continued occurrence reflects challenges that staff face in giving safety the priority it deserves
- There is a need for a fundamental cultural shift in the way that safety is understood and managed in the NHS

What did we find?

- Ever-increasing patient demand and staff shortages leave little time for staff to implement safety guidance effectively
- Rigid hierarchical structures make it harder for junior staff to raise concerns
- Patient safety alerts are useful, but the combination of the above, means they can be seen as ‘another thing to do’

The current patient safety landscape is confused and complex…

…this makes it difficult for trusts to prioritise what needs to be done.

- Throughout our review we heard how trusts receive multiple messages from various national bodies
- There needs to be better communication and coordination between national bodies and great clarity of their roles
- CCGs providing support and following a Never Event, is seen as a positive however this is variable
- No clear system for staff to learn from each other at a national level
- Local reporting systems are often poor quality and do not support staff well
- Patient safety systems are more likely to be effective, if patients were involved in their designed – however this is often not done well

Healthcare is a high-risk activity…

…but it is not recognised as such

- We must learn from other industries facing similar challenges where risks are identified and managed proactively
- In those industries, all staff are trained to ensure that everything has been done to reduce risks to an acceptable level
- Team dynamics, situational awareness and human factors are seen as central to how they work
- Raising safety concerns is expected behaviour of all staff
- Safety protocols are followed without question
- Technology is used where appropriate to reduce error

How do we achieve this?

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- Everyone must play a part in prioritising patient safety
- Leaders must have the appropriate training, expertise and support to drive safety improvement in trusts
- The wider challenge for us all is to effect the cultural change that we need and to have the humility to accept that we all make errors
- Change to our approach is essential in creating a just culture where learning is shared and solutions are created to manage risk

Thank you

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www.cqc.org.uk/opening-door-change

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