Workshop C22: Learning from the Mid-Staffordshire Case in the English NHS

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

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Session Objectives

• Describe how the problems at Mid Staffs arose

• Identify the early signs of similar problems in other healthcare systems

• Identify one way of developing early warning systems from data analysis, patient and staffs feedback and surveys and timely inspections and investigations
Background of Mid-Staffordshire

- 2004-2009 – High Hospital Standardized Mortality Rates
- Many complaints from staff, patients, and families
- Investigation began in 2009
- The Francis Report – March 2013
  - Many were harmed
  - Signals ignored
  - Basic care standards were violated
- David Cameron, PM, announced “Zero Harm” goal
- Committee – Berwick Chair
- The Keogh Report – 14 high HSMR hospitals
- Report: August 6, 2013
Mid Staffs: Operations on the jejunum – sent July 2007

Mid Staffs: Aortic, peripheral, and visceral artery aneurysms – sent Aug 2007
Mid Staffs coding of palliative care vs HSMR

[Graph showing the percentage of deaths coded as palliative care in England, Mid Staffordshire NHS Foundation Trust (RJD), and HSMR Mid Staffordshire NHS Foundation Trust over time from 2004 to 2011.]

Distribution of Waiting Times for Patients Admitted to Stafford Hospital A&E

[Graph showing the distribution of waiting times for patients admitted to Stafford Hospital A&E from April to December 2007.]

April-December 2007
(from Taylor P. London Review of Books)
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. Recognize 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. Recognize 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

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 organizations
  • 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 organizations from wards to the boards of Trusts.
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 organizations should ensure that staff are present in appropriate numbers to provide safe care at all times and are well-supported.

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 organization. Its leaders should create and support the capability for learning, and therefore change, at scale, within the NHS.
  • Collaborative Improvement Networks
Suggested Improvement Skills

- Setting goals and measures
- Identifying problems
- Mapping processes
- Testing change
- Simple Standardisation
- Team Behaviour

Mortality Rates from Circulatory Disease – Progress Against a Target

- Setting goals and measures
- Implementation of portfolio and management
- Identifying problems
- Simple understanding variation
- Managing spread
- Simple waste reduction and standardisation
- Understands microsystems and systems thinking

Source: NCHOD
International Mortality from Conditions Considered Amenable to Healthcare (1997/98 - 2002/03)

<table>
<thead>
<tr>
<th>Country</th>
<th>% decrease 1997/98-2002/03</th>
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<tbody>
<tr>
<td>France</td>
<td>14.5%</td>
</tr>
<tr>
<td>Australia</td>
<td>19.3%</td>
</tr>
<tr>
<td>Canada</td>
<td>13.5%</td>
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<tr>
<td>Germany</td>
<td>15.1%</td>
</tr>
<tr>
<td>United States</td>
<td>4.3%</td>
</tr>
<tr>
<td>United Kingdom</td>
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</tbody>
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VI. Measurement and Transparency

- Transparency should be complete, timely and unequivocal. All non-personal data on quality and safety, whether assembled by government, organizations, or professional societies, should be shared in a timely fashion with all parties who want it, including, in accessible form, with the public.

- All organizations should seek out the patient and carer voice as an essential asset in monitoring the safety and quality of care.
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 organizations, 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.
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.

Major Media Interest on August 6

- Mandatory Staffing Ratios
- Criminal Sanctions
- A “Duty of Candor”
- How Many Other “Mid-Staffordshires”?
- How Can We Trust the Leaders?
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**.

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**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 Organization Leaders and Boards:**

- Listen to and involve patients and carers in every organizational process and at every step in their care.
- Monitor the quality and safety of care constantly, including variation within the organization.
- 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-organizational collaboratives – networks – in which teams can learn from and teach each other.
- Use evidence-based tools to ensure adequate staffing levels.

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**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.