

Key learning from the Berwick report (Improving the safety of patients in England)

Professor Don Berwick was asked by the PM and SoS to advise on how to improve the quality and safety of care in the NHS. He set up an advisory committee of experts in organisational theory, quality improvement, safety and systems to distil the lessons from Mid Staffordshire into the changes that are needed.

Problems identified	Required change from the system to address these
Patient safety problems exist throughout the NHS as with every other health care system in the world	Recognise with clarity and courage the need for wide systemic change
NHS staff are not to blame – in the vast majority of cases it is the systems, procedures, conditions, environment and constraints they face that lead to patient safety problems	Abandon blame as a tool and trust the goodwill and good intentions of staff Reassert the primacy of working with patients and carers to achieve health care goals
Incorrect priorities do damage: other goals are important, but the central focus must always be on patients	Use quantitative targets with caution. Such goals do have an important role <i>en route</i> to progress, but should never displace the primary goal of better care
In some instances, clear warning signals abounded and were not heeded, especially the voices of patients and carers	Recognise that transparency is essential and expect and insist on it
When responsibility is diffused, it is not clearly owned: with too many in charge, no-one is	Ensure that responsibility for functions related to safety and improvement are vested clearly and simply
Improvement needs a system of support: the NHS needs a considered, resourced and driven agenda of capability-building in order to deliver continuous improvement	Give the people of the NHS career-long help to learn, master and apply modern methods for quality control, quality improvement and quality planning
Fear is toxic to both safety and improvement	Make sure pride and joy in work, not fear, infuse the NHS

Recommendations

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

The quality of patient care should come before all other considerations in the leadership and conduct of the NHS, and patient safety is the keystone dimension of quality.

Resource constraints will undoubtedly continue in the NHS. There are two ways to deal with this reality. One is by simply cutting budgets and placing the burden on staff of caring with fewer resources. The other, better, way is through improvement – introducing new models of care and new partnerships among clinicians, patients and carers that can produce better care at lower cost.

- 2. All leaders concerned with NHS healthcare should place quality of care in general, and patient safety in particular, at the top of their priorities for investment, inquiry, improvement, regular reporting, encouragement and support.**

All leadership bodies should regularly review data and actions on quality, patient safety and continual improvement at Board meetings.

Boards should employ structures and processes to engage regularly and fully with patients and carers, to understand their perspectives on and contributions to patient safety.

- 3. Patients and their carers should be present, powerful and involved at all levels of healthcare organisations from wards to the boards of Trusts.**

The goal is not for patients and carers to be the passive recipients of increased engagement, but rather to achieve a pervasive culture that welcomes authentic patient partnership – in their own care, and in the processes of designing and delivering care.

- 4. 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.**

Staffing levels should be consistent with the scientific evidence on safe staffing, adjusted to patient acuity and the local context. Boards and leaders should utilise evidence-based acuity tools and scientific principles to determine the staffing they require in order to safely meet their patients' needs. They should make their conclusions public and easily accessible to patients and carers and accountable to regulators.

Leaders should foster good teamwork in care, ask teams to set challenging and measurable team objectives, facilitate better coordination and encourage teams to regularly take time out to review their performance and how it can be improved.

Leaders should actively support staff by excellent human resource practices, promoting staff health and well-being, cultivating a positive organisational climate, involving staff in decision-making and innovation, recognising good performance, addressing systems problems and providing staff with helpful feedback.

Each organisation should be expected to listen to the voice of staff, such as through department and ward level cultural and teamwork safety surveys, to help monitor the safety and quality of care and variation among units.

- 5. Mastery of quality and safety sciences and practices should be part of initial preparation and lifelong education of all health care professionals, including managers and executives.**
- 6. 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.**

The entire NHS should commit to lifelong learning about patient safety and quality of care through customised training for the entire workforce on such topics as safety science, quality improvement methods, approaches to compassionate care and teamwork.

NHS providers should invest in building capability within their organisations to enable staff to contribute to improvement of the quality and safety of services to patients. A properly resourced capability programme must be in place within 12 months.

Every NHS organisation should participate in one or more collaborative improvement networks as the norm.

- 7. 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.**
- 8. All organisations should seek out the patient and carer voice as an essential asset in monitoring the safety and quality of care.**

Patient safety cannot be improved without active interrogation of information that is generated primarily for learning, not punishment, and is for use primarily at the front line. Information should include: the perspective of patients and their families; measures of harm; measures of the reliability of critical safety processes; information on practices that encourage the monitoring of safety on a day to day basis; on the capacity to anticipate safety problems; and on the capacity to respond and learn from safety information.

Leaders must understand the variation in their organisation, not just among organisations, in order to improve.

- 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 wilful or reckless neglect or mistreatment.**