Preventing patient harm – Everybody’s business

Following the death of toddler Sam Morrish back in 2011, the Patients Association received assurances that NHS 111 staff would receive better training and support to help them respond to, and recognise, serious conditions after their failure to identify Sam’s case as an emergency. All these years on, it is clear that lessons were not learnt from this case, and the subsequent death of another toddler, William Mead, highlighted the tragic consequences of this failure to act.

I write this commentary in response to the findings of the investigation into William Mead’s death, led by NHS England and Kernow CCG, published recently. Progress against those recommendations has also been published. I add my own reflections based on my understanding of wider developments in the system.

William Mead’s family have undertaken an inspiring campaign, the consequences of which will hopefully be felt for a long time. Lessons, it seems, are finally being learnt – future missed diagnosis may be prevented. Avoidable harm and more tragic deaths will be reduced if promises the family have gained from many, including the Health Secretary, are delivered.

For over four years I have been exploring and trying to change how patients’ harm events are responded to. I now campaign alongside the Patients Association as a Patient Safety Ambassador. William Mead’s family campaign is both inspiring, educative and sobering for a number of reasons.

Firstly the family has finally been put at the centre of the investigation and the value of this is explicitly recognised by the bodies involved. This has so rarely occurred in the past.

Secondly the investigation and recommendations have drawn on serious responsible expert bodies including NHS England, the Clinical Commissioning Group (CCG), and also independent experts. Once again, empowered investigators with a service delivery and change focus are all too rare.

Both these aspects are vital with cases like this where a catalogue of serious service failures are identified, and especially where this relates to a widely known medical challenge, in this situation identifying sepsis promptly. Serious learning and profound and prolonged reflection by all providers and commissioners of services has resulted. One cannot underestimate what this family has achieved.

But there is a third lesson. The journey of the Mead family will not have been easy. Achieving any proper investigation, never mind achieving robust change, involves enormous challenges, frustrations, obstacles and much more. The Parliamentary Health Service Ombudsman (PHSO) itself found that too many complaints are not adequately investigated. Worse PHSO itself still the main body charged to address these systemic failing has itself been strongly criticised by many including the Patients Association. It is just as bad, at times even worse, for whistle-blowers who dare speak out. These challenges are vividly illustrated in the eye-opening books by James Titcombe and David Drew.

This failure at a system level must end. A step forward has been made by the creation of Healthcare Safety Investigation Branch (HSIB) which should fully up and running by April 2017. However like many commentators I am concerned about its small scale (given the massive number of high risk events and systemic failings to address them), its lack of independence and lack of any clear independent scrutiny of its function.

HSIB’s initial impact will be token at best and these concerns cannot be separated from the ongoing scandal regarding whistle-blowers treatment when raising similar issues. These serious concerns about HSIB as it has been presently set up are confirmed in the critical report last week by the same
Parliamentary Committee that proposed a NHS investigation service in the first place, which was based on a report by national safety experts.

The Secretary of State and HSIB have immediate serious questions to address—after so many scandals I believe patients, families, whistle-blowers and the public demand and deserve more than token or weak initiatives.

Families have enough to cope with having experienced harm to a loved one. And only a fraction are able and willing to fight on, driven by their understanding of the profound injustice. To paraphrase others while to err is human, to cover up and not learn and change is unforgiveable. The grief, anger and desire to prevent others suffering the same way becomes a fight for a greater justice. But we simply cannot make do with a system relying on families going down this often tortuous and torturous path.

Hospitals and other health providers have to change so there is a culture of listening and learning, when challenged by an incident of actual or potential harm. This will be a major challenge traditional ways of medical and nursing teams work as well as how patients and families are in integrated into the processes. (See following links, click, click, and click).

It must be noted that, unlike in the Mead family case, NHS England does not usually investigate events. However there is another perspective to this. The business of reducing patients harm rests with many people and organisations directly and indirectly. And there is a world leading incident reporting system in this country which is being continually refined and developed to become more of an incident ‘learning and responding’ system. There will always be a need to report incidents both locally and nationally, so both local and national patterns can be elucidated and acted upon.

I write this as someone whose late mother endured multiple and very painful end of life care failings (itself, like sepsis, another long standing national concern for too many, detrimentally affecting tens of thousands of people a year). Like too many other families, I have experienced years of ineffective ‘investigations’. But I have also seen the valuable role of NHS England when it does respond to identified risks. In my case, their patient safety division were able to start serious action on a specific medication risk I had identified with supporting evidence. Moreover my involvement in this process continues and is welcomed: this is how it should be.

NHS England does allow families and patients to report ‘Patient safety incidents’ which they define as “any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving NHS-funded healthcare”. This route is anonymous and can’t give you direct advice or lead to an investigation, but it does give NHS Improvement (who are the body that now review these reports) a chance to consider if it could be part of a wider pattern of safety concern that the NHS as a whole can learn from.

So in conclusion, as a Patient Safety Ambassador for the Patients Association I urge patients and their families to use this reporting route via NHS England if it is appropriate. I suggest that even if you decide not go down the formal complaint process you report the safety issue and harm caused to the health provider involved and provide a copy to your MP and the relevant Clinical Commissioning Group (CCG), Care Quality Commission ( CQC, Healthwatch, Parliamentary Health Service Ombudsman( PHSO), General Medical Council (GMC) or Nursing and Midwifery Council (NMC) or relevant Royal College/ professional body- especially if harm has been caused and there is a suggestion that policies have been breached or are inadequate. All these bodies have certain responsibilities and need to be informed of ongoing concerns in case it links with other cases or incidents or services they are examining or reviewing.
Please note, apart from the provider, they are not obliged to investigate but they should reply and acknowledge and log your concerns. However in my case it was via a Royal College of Anaesthetist Safety Committee that my concerns were taken to NHS England.

Finally, I would like to conclude that I used the term ‘business’ with trepidation in the title. But at this time when the NHS is expected to provide more for less (totally unrealistic by my reckoning) it is important that any harmful event is reported to allow a full and fair understanding what may be the cause of it. We all have responsibilities here to ensure our NHS continues to improve, use its resources to the benefit of us all (‘*do no harm*’) and that it learns from the tragic failings and errors. Mistakes will always be made in a system dealing with life and death issues daily. We all have a role to play to ensure these are properly noted and learnt from. My story can be found by clicking [here](#).

I continue to campaign and network via the Patients’ Association as a Patient Safety Ambassador.

The Patient Association is currently updating its guidance for patients who want to raise patient safety issues or complain about other matters. For further information [www.patients-association.com](http://www.patients-association.com)

*Richard von Abendorff*  
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The Patients Association is fully supportive of the ideas expressed in this article and call for a truly independent investigative body where patients and carers are central and truly listened to.

In Richard’s voluntary role as a patient safety ambassador for the Patients Association, he welcomes feedback via the [mailbox@patients-association.com](mailto:mailbox@patients-association.com) to this article from patients and families as well as any staff engaged in delivering, ensuring or improving patient safety and the NHS response to safety concerns. While he cannot promise an individual detailed response he will endeavour to read and digest other’s experiences, perspectives and knowledge.