HSJ [EXPERT BRIEFING]

Lintern's Risk Register

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Industrialising safety in healthcare

Everything you need to stay up to date on patient safety and workforce, plus my take on the most important under-the-radar stories. From patient safety correspondent Shaun Lintern

Contact me in confidence here. *Shaun Lintern, patient safety correspondent*

It isn't blasphemy to ask for better care

Before the festive break I was invited to speak at a patient safety conference in London organised by Datix. You can view the full talk here.

My message was one many will be familiar with. The NHS harms too many patients, makes enemies of families just seeking answers, and fails to learn and improve. In short I described how a "cottage industry" of quality improvement re-invents the wheel and fails to embed change. Sometimes this is the fault of poor behaviours but more often is a consequence of organisational memory being lost. My argument was for a more industrialised response, as has been witnessed in aviation, the oil industry and NASA.

On that theme, the new chief investigator for the NHS, Keith Conradi, gave me an exclusive interview to discuss the early outline of his plans for the new Healthcare Safety Investigation Branch. As *HSJ* readers commented, Mr Conradi was refreshing in his honesty about the powers HSIB needed and what it could and could not realistically deliver.

A safe staffing let down until next time

Before Christmas, NHS Improvement published its new draft guidance on safe staffing in acute wards and learning disability settings. The full documents are available here.

The genesis of this work started with the appalling staffing levels at Mid Staffs, where the ratio of qualified to unqualified nurses flipped from 3:2 to 2:3. In his report on the scandal, Sir Robert Francis QC recommended NICE should draw up "evidence based tools for establishing what each service is likely to require as a minimum in terms of staff numbers and skill mix".

In 2015 NHS England and the Department of Health colluded to stop NICE doing the necessary work (it was weeks away from recommending minimum ratios in A&E departments) and NHS Improvement's guidance fails the Francis recommendation. It does not establish what each service should have, it allows variation in staffing levels to continue.

Worse, it recommends trusts consider delegating care tasks to other staff, reducing nursing to a task based role without evidence that this is safe. It also expects trusts to measure their staffing against the simplistic care hours per patient day metric – an aggregate average which takes into account nothing but numbers of staff and patients.

All that said, the guidance is easy to follow and includes references to evidence based research that clearly does show the link between staffing levels and patient outcomes. It makes clear that professional judgement cannot be relied on alone and that trusts need to investigate the acuity of their patients and triangulate that with incident data. This is something many trusts still don't do – a cursory glance at Care Quality Commission inspection reports show this is all too common.

Leaders in the NHS have succeeded in delaying and relegating the importance of safe staffing levels such that the publication of this guidance was barely noticed compared to the packed press conference for NICE's first efforts.

Some at the top of the NHS may be celebrating this successful downgrade of one of the key warnings from the Mid Staffs scandal. If another major scandal emerges, they could be faced with the question of why they didn't do more.

Careful, the NMC is watching you

It's debatable whether the Nursing and Midwifery Council would be found unfit to practise if measured against its own standards and code of conduct for nurses. The watchdog continues to wallow in some pretty murky depths when it comes to defending its actions surrounding the Morecambe Bay scandal.

It refuses to release a review of its handling over one Morecambe Bay midwife who was sacked by the trust following the death of a baby last year but who was allowed to continue working for eight years before being struck off for failures at the same trust. The NMC tried to claim the review was legally privileged and it couldn't release the report, which was written by Mid Staffs inquiry lawyer Tom Kark QC.

Now an email from NMC director of fitness to practice, Sarah Paige, reveals: "It is covered by legal privilege, as between Tom Kark and the NMC, but we could waive this if we wanted to disclose it in full." In other words releasing the report was a choice and the NMC opted against transparency.

Worse still, a data subject access request by James Titcombe, whose son Joshua died after failures at Morecambe Bay in 2008, reveals the NMC launched a surveillance programme to monitor the grieving dad in 2016. A Google alert was set up searching for his name, his attendance at events and speaking arrangements was watched and his presence on social media was analysed. The emails released by the NMC are excessively redacted – it employed a law firm to do the work.

The NMC has said it will establish a review of its handling of the entire Morecambe Bay issue but has yet to reveal details of this or who will lead it. Given its past behaviour I will be watching this closely.

Why does any of this matter? When regulators fail to properly act it sends signals, it promulgates the wrong approach and in some cases, such as Morecambe Bay, it can even allow scandals to rage on for longer than necessary. Patients are put at risk.

The NMC has come a long way under the leadership of chief executive Jackie Smith. In May last year I suggested she faced a choice of whether to continue reforming the

watchdog or concentrate on consolidating her own position, focusing on reputation management. Time is running out for her to demonstrate she's made the right choice.

Patient safety picks

[Police investigate 'tampered' saline bags at hospital trust]

[230 patients wait over 12 hours in A&E amid beds dispute]

[NHS has 'nothing to fear' from new investigation body, says chief]

[NHS England to press ahead with court appeal]

[Exclusive: NHS England warned of bed 'crisis' 10 days before patient trolley deaths]

[IT director and contractor jailed over corrupt payments]

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