



House of Commons  
Committee of Public Accounts

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# A safer place for patients: learning to improve patient safety

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**Fifty-first Report of  
Session 2005–06**

*Report, together with formal minutes,  
oral and written evidence*

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## The Committee of Public Accounts

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### Committee staff

The current staff of the Committee is Nick Wright (Clerk), Christine Randall (Committee Assistant), Emma Sawyer (Committee Assistant), Ronnie Jefferson (Secretary), and Luke Robinson (Media Officer).

### Contacts

All correspondence should be addressed to the Clerk, Committee of Public Accounts, House of Commons, 7 Millbank, London SW1P 3JA. The telephone number for general enquiries is 020 7219 5708; the Committee’s email address is [pubaccom@parliament.uk](mailto:pubaccom@parliament.uk).

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## Summary

Every day the NHS treats over one million people successfully. Healthcare does however rely on a range of complex interactions of people, skills, technologies and drugs. Sometimes surgical treatments go wrong, medication errors occur and patients can fall or have other accidents.

The drive to improve patient safety started in 2000 with the Chief Medical Officer's report *An organisation with a memory*. This found that a blame culture and the lack of a national system for sharing lessons learnt were key barriers to identifying and then reducing the number of patient safety incidents. The Report estimated that one in ten patients admitted to NHS hospitals are unintentionally harmed, costing the NHS around £2 billion a year in extra bed days and some £400 million in settled clinical negligence claims. Around 50% of incidents could be avoided if lessons from previous incidents had been learnt. These findings were similar to those of other developed countries.

In response, the Department of Health (the Department) published *Building a safer NHS for patients*, which set out the Government's plans, timetable and targets to promote patient safety, including establishing the National Patient Safety Agency. The Agency's objectives were to develop a mandatory national reporting scheme by December 2001 for incidents and near misses, assimilate other safety-related information from a variety of existing systems, learn lessons and develop solutions. At the time trusts had to report to one or more of over 30 different organisations depending on the type of incident. There was an expectation therefore that the creation of the Agency would reduce the complex regulatory framework for monitoring quality and safety.

On the basis of a Report by the Comptroller and Auditor General,<sup>1</sup> the Committee took evidence from the Department of Health, the National Patient Safety Agency and the Chief Medical Officer for England.

The Committee found that in 2004–05 some 974,000 patient safety incidents and near misses were recorded on NHS trusts' reporting systems. NHS trusts need to bring down the level of avoidable incidents, particularly those leading to serious harm and death, through rigorous implementation of safety alerts and adoption of high impact, evidence based solutions such as those promulgated by the National Patient Safety Agency and the Institute of Innovation and Improvement.

There have been some notable improvements at NHS trust level in developing a more open and fair reporting culture, reflected in the year on year increase in the numbers of reported incidents and near misses. Nevertheless, under-reporting remains a problem (trusts estimate that on average 22% of incidents go unreported, mainly medication errors and incidents leading to serious harm) and similar types of trusts report widely different levels of incidents per 1,000 members of staff. Few trusts have formally evaluated their safety culture. Furthermore, trusts have not done enough to inform patients when things go

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1 C&AG's Report, *A safer place for patients: learning to improve patient safety* (HC 456, Session 2005–06)

wrong or to involve patients in developing solutions to incidents.

Insufficient progress has been made in achieving the Department's plans in *Building a Safer NHS for Patients* and there is a question mark over the value for money being achieved by the National Patient Safety Agency, evidenced in the main by the delays and cost over-runs in establishing its National Reporting and Learning System and in the limited feedback of solutions to reduce serious incident that has, so far, been provided to trusts. The National Patient Safety Agency has also failed to evaluate and promulgate solutions that have been developed at trust level.

## Conclusions and recommendations

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1. **Insufficient progress has been made in achieving the Department's plans in Building a Safer NHS for Patients.** In particular the National Patient Safety Agency was very late in delivering the National Reporting and Learning System and has provided only limited feedback to NHS trusts on solutions to reduce serious incidents. The National Patient Safety Agency has also failed to evaluate and promulgate solutions that have been developed at trust level. As a result the Agency has yet to demonstrate good value for money.
2. **Trusts estimated that on average around 22% of incidents and 39% of near misses go un-reported, and that medication errors and incidents leading to serious harm are the least likely to be reported.** The National Patient Safety Agency should compare its own data with the incident reporting data collected by the National Audit Office. It should bring together trusts with low levels of reporting and those that have achieved high reporting rates to help improve incident and near miss reporting. The Healthcare Commission should evaluate compliance with reporting requirements as part of its performance assessment process.
3. **The lack of accurate information on serious incidents and deaths makes it difficult for the NHS to evaluate risk or get a grip on reducing high risk incidents.** The National Patient Safety Agency needs to obtain a more precise understanding of the extent and causes of death and serious harm. To do so, it needs to collect information on the contributory factors and develop a more targeted, risk based, approach to solutions aimed at reducing such incidents.
4. **Doctors are less likely to report an incident than other staff groups.** The National Patient Safety Agency has run a national initiative to encourage reporting by junior doctors, and should promulgate the lessons from this initiative across the NHS. Trusts should evaluate their own levels of under-reporting and target specific training and feedback at those groups of staff that are less likely to report.
5. **Although most trusts stated their safety culture had become more open and fair, less than half of trusts had conducted a formal assessment of progress.** In 2004, 23% of trusts felt they had an open and fair culture throughout their organisation, and another 72% felt their safety culture was predominantly open and fair. By 2005, the percentage of trusts rating themselves as having an open and fair culture throughout had increased to 32%, while those judging their culture only predominantly open and fair had reduced to 65%. All trusts should assess their safety culture using one of the established tools, such as those listed in the National Patient Safety Agency's guidance *Seven steps to patient safety*, and implement action plans to address the issues identified.
6. **Disciplinary action may be an appropriate response when patient safety is at risk, but the perception amongst nursing and other non-medical staff is that they risk suspicion if they report a serious incident.** Our predecessors' Report on the management of suspensions (HC 296, 2003–04) identified an over-reliance on disciplinary measures. The Department still does not monitor the nature and length of non-medical staff suspensions, or the management action taken on them. The

Department and NHS trusts should act on the previous Committee's recommendation to extend the role of the National Clinical Assessment Service to cover all staff.

7. **Patient safety alerts and other solutions are not always complied with though trusts self-certify that they have implemented them.** For example, the Chief Medical Officer's 2004 report found that 50 days after the deadline for implementing a safety alert on oral methotrexate, only 54% of organisations had completed the actions required to reduce harm. In evaluating trusts' self assessments the Healthcare Commission with the Standards for Better Health should require trusts to provide evidence on the extent of compliance. During inspection visits they should evaluate and report on how well alerts and other solutions have been put into practice.
8. **Only 24% of trusts routinely inform patients involved in a reported incident and 6% do not involve patients at all.** Only 69% of trusts had criteria for staff to follow. Using the National Patient Safety Agency guidance on *Being Open*, all trusts should as a matter of course inform patients and their carers if they have been involved in an incident, even if they suffered no harm. Patients and carers should also be consulted to help identify solutions.
9. **It took until July 2005, for the National Patient Safety Agency to produce its first feedback report to trusts on the number of incidents reported and some specific solutions to particular types of incidents.** The Department should hold the National Patient Safety Agency to their commitment to produce feedback reports at least quarterly. These feedback reports should include illustrative business cases to demonstrate the cost-effectiveness of implementing solutions to specific problems.
10. **The National Reporting and Learning System has not, as hoped, helped simplify the complexity for trusts in reporting incidents.** The Department, NHS Connecting for Health and the National Patient Safety Agency should agree a plan and timetable for rationalising the reporting routes so that within the next two to three years trusts need make only one report of an incident, which is then automatically distributed to the relevant organisation.
11. **To choose between hospitals under the NHS Choice agenda, patients will need access to robust information on patient safety, including comparable information from independent sector providers.** The National Patient Safety Agency anonymises the data it collects and was not tooled up to provide comparable information. The Department needs to agree whether and how such information will now be provided and who will be responsible for publishing the data.
12. **The taxonomy of the National Reporting and Learning System differs from many local trust descriptions and classifications of incidents and also from taxonomies used by other countries.** The World Health Organisation is developing an international taxonomy. The National Patient Safety Agency should either adopt this taxonomy or align its taxonomy fully to it, though with scope to meet additional requirements that the Agency may deem necessary.

# 1 Awareness of patient safety incidents

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1. Every day over one million people are treated successfully by the National Health Service. Although patient care is generally of a high standard, the scale and complexity of patient interventions means that patients can sometimes suffer unintended harm. Other National Audit Office and Committee of Public Accounts' Reports have highlighted concerns that the NHS has limited information on the extent and impact of clinical and non-clinical incidents; and that trusts need to improve their understanding of the causes, learn from them, and share good practice across the NHS more effectively.<sup>2</sup>

2. The system for monitoring and reporting incidents has, over time, become very complex (**Figure 1**). By 2000, there were more than 30 different reporting routes. The Chief Medical Officer's report, *An organisation with a memory* (2000), acknowledged that the NHS was failing to learn from things that went wrong and had limited systems in place to put things right. The Department estimated that one in ten patients admitted to NHS hospitals would be unintentionally harmed, a rate it believed to be roughly similar to other developed countries. Around 50% of these incidents could have been avoided if lessons from previous incidents had been learned.<sup>3</sup>

3. The Chief Medical Officer's report identified the conditions needed to improve people's confidence in the NHS. It advocated a change in the safety culture, from one based on blame, to an open reporting culture to transform the NHS into an effective learning organisation. Central to this change was the need for a national reporting system, with a comprehensive taxonomy for incidents, and robust methods for evaluating trends in incident rates.<sup>4</sup>

4. The National Audit Office census of acute, mental health and ambulance trusts in September 2004 (updated in August 2005) was the first co-ordinated attempt to analyse the extent and impact of the reporting problem and what was being done at trust level to address the issue. It found that all trusts had established effective reporting systems, although under-reporting remained a problem with some staff groups, types of incidents and near misses.<sup>5</sup>

5. The census revealed that in 2004–05 a total of 974,000 incidents and near misses, including some 2,181 patient deaths, had been recorded by trusts. Some trusts' incident reporting systems recorded few incidents and others recorded many thousands (**Figure 2**). This data on its own does not provide a clear indication of how safe a trust is. Those with low levels of incidents per 1,000 members of staff may be discouraging reporting and vice versa.

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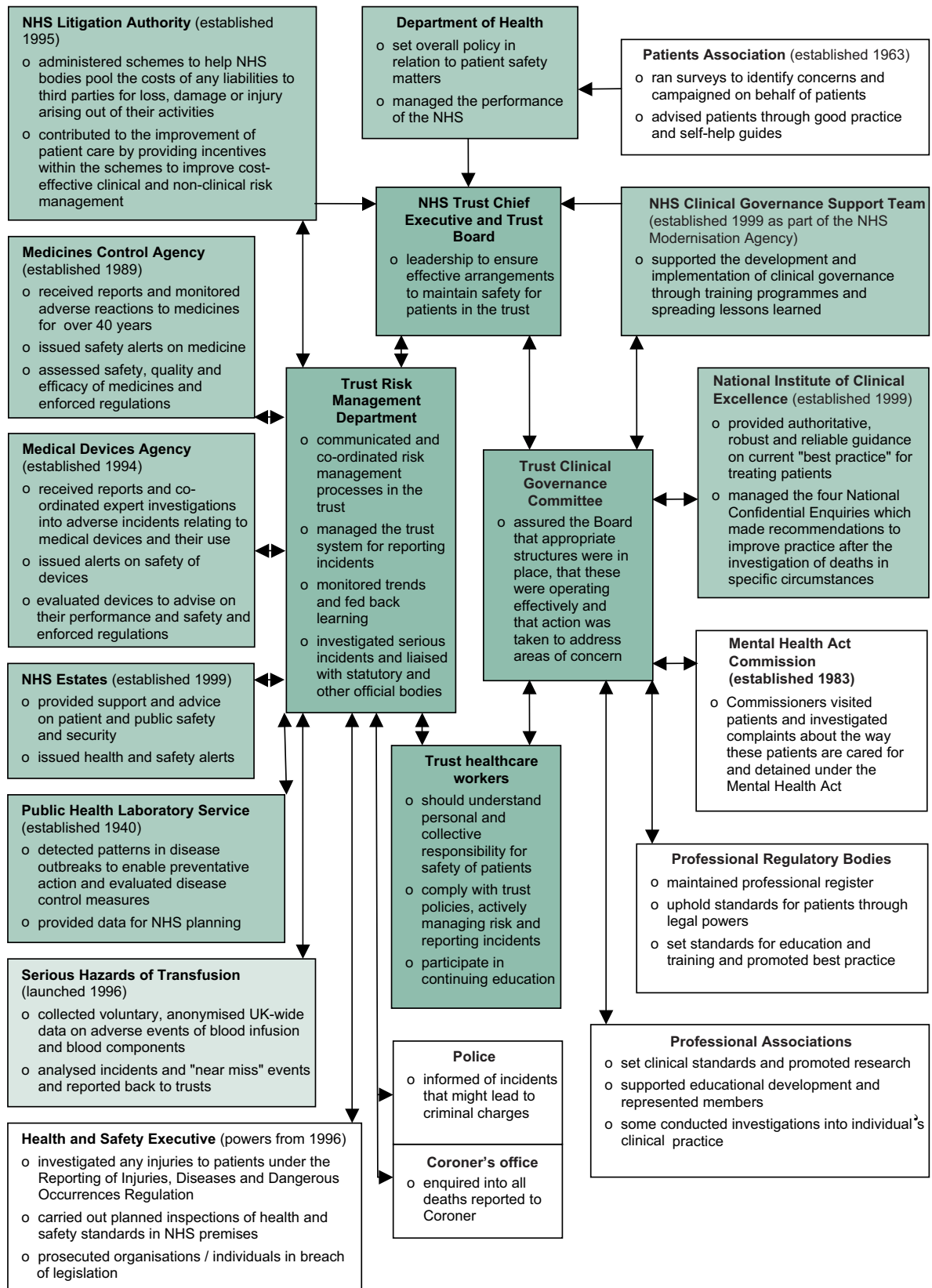
2 C&AG's Report, Executive Summary paras 1–2, 1.1 and Appendix 1

3 *ibid*, Executive Summary paras 1, 14, 1.1; Qq 4, 23

4 C&AG's Report, paras 1.1, 2.27

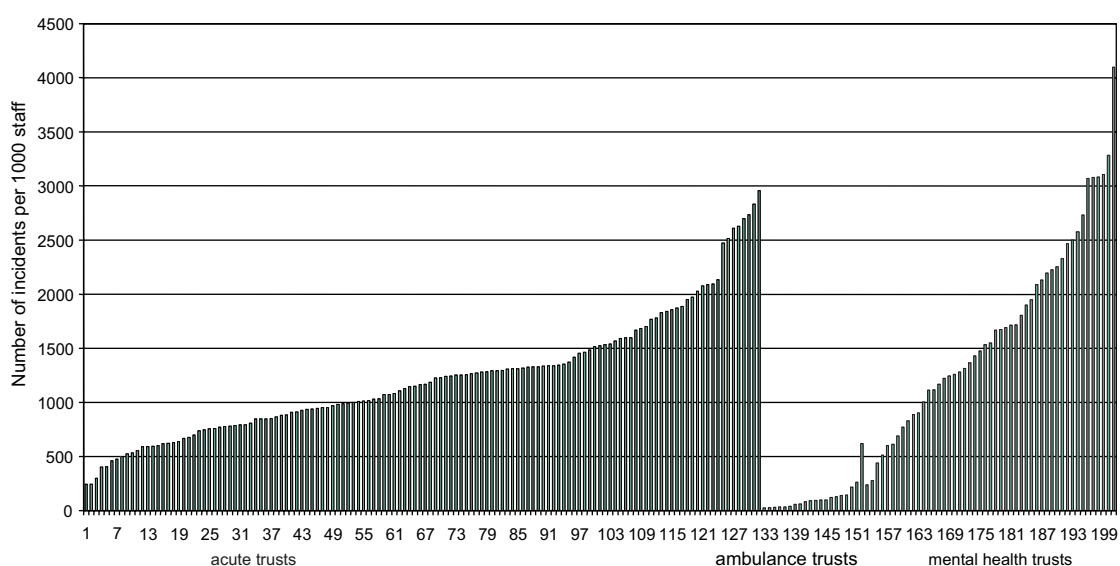
5 *ibid*, Executive Summary paras 5–6 and Appendix 2

**Figure 1: Key organisations in the complex regulatory and support landscape for patient safety from an NHS trust perspective (pre 2001)**



We also found that there was no correlation between the numbers of performance “stars” that a trust had received and the number of incidents reported. The figure on reported deaths also differs from other published estimates but in reality the NHS simply does not know.<sup>6</sup>

**Figure 2: In 2004–05 similar types of trusts reported widely different numbers of incidents per 1000 members of staff**



Source: National Audit Office

6. Local reporting is dependent on staff willingness and perception of what, when and how to report. Poorly designed forms, failure to recognise that an incident needs reporting, being too busy and a lack of feedback on the outcome of a report are the main reasons for not reporting. Trusts said that fear of retribution undermines staff’s willingness to report. They also named concerns about the risk of a claim under the NHS clinical negligence scheme as reasons cited by staff as having discouraged them from apologising or from being open following an incident.<sup>7</sup>

7. Few NHS acute trusts routinely told patients when they had been involved in an incident. For example, only 24% routinely informed patients when they were involved in an incident and 6% did not inform patients at all. This lack of transparency and openness has a detrimental effect on patients’ confidence in the NHS and in their ability to manage their own health. There may also be implications for their continuing care as patients’ general practitioners (GPs) are also likely to be unaware of the incident.<sup>8</sup>

8. A few trust boards include information on patient safety incidents in their trust board papers but most trusts do not publish the numbers of incidents. Consequently, whilst this information may be considered relevant to patients in exercising patient choice, GPs do not have such information. Neither do they have any information on incidents in

6 C&AG’s Report, Figures 1, 5, 6, paras 2.10–2.11; Qq 54–57, 127

7 C&AG’s Report, Figure 9; Qq 2, 28, 137

8 C&AG’s Report, para 1.10; Qq 134, 138–139

independent provider organisations. The only information on safety available to GPs is on trusts MRSA bacteraemia rates and, from 2006, patients will also be able to access reports from the Healthcare Commission on achievements against the Standards for Better Health.<sup>9</sup>

## 2 Action to improve patient safety

9. In its 2001 policy document, *Building a Safer NHS for Patients*, the Department advocated that patient safety and risk reduction should be at the heart of its framework for improving quality of clinical care. A key action was the establishment of the National Patient Safety Agency in July 2001, to collect and analyse information, assimilate other safety-related information from a variety of existing reporting systems, learn lessons and produce solutions. The Department also advocated that lessons could be learned from others, in particular from the airline industry.<sup>10</sup>

10. The Department allocated an annual budget of around £15 million to the Agency, which by 2004–05 had increased to £17 million and in 2005–06, following an increase in its remit as a result of reconfiguring the Department of Health’s Arm’s Length Bodies, was £35 million (**Figure 3**).<sup>11</sup>

**Figure 3: A breakdown of the National Patient Safety Agency’s 2005–06 budget**

<b>Total National Patient Safety Agency budget 2005–06</b>	<b>£35.154 million</b>
Original National Patient Safety Agency budget plus corporate services for all functions mentioned below (IT, Human Resources, facilities, communications, finance and Board)	£19.218 million
National Clinical Assessment Services budget	£7.36 million
Central Office for Research Ethics Committees budget	£5.175 million
Confidential Enquiries	£3.034 million

Source: *National Patient Safety Agency*

Note: In 2005–06, the pay budget was £17.587 million, or 50% of the overall spend (excludes cost of staff engaged by the confidential enquiries.)

11. The National Patient Safety Agency was charged with supporting an open and fair culture in the NHS, where staff feel they can report concerns without fear but on the understanding that they are accountable for unsafe acts. It has made some progress, for example its *Seven steps for patient safety* document and guidance on good practice in dealing with staff involved in incidents. It has also trained 8,000 staff in contributory factors analysis, provided leadership training to 154 non-executives from 113 trust boards and issued guidance for chief executives on their role in promoting safety. The Department believes that there has been a change in attitudes towards safety and, paradoxically, sees the increase in reported incidents as an indication of an improved safety culture in the NHS.<sup>12</sup>

<sup>10</sup> C&AG’s Report, para 1.2

<sup>11</sup> Qq 6, 93, 100–101

<sup>12</sup> C&AG’s Report, para 1.3, 1.8; Qq 28–29, 88

12. A key target for the National Patient Safety Agency was to develop a national reporting system by December 2001, with all trusts to provide information to it by the end of 2002. The early years of developing its “National Reporting and Learning System” have been beset by problems. The system was three years late in being linked to trusts’ own reporting systems and was over-spent by approximately £1 million. In addition, the parallel, anonymous, electronic reporting system (e-Form) was only available from September 2004.<sup>13</sup>

13. The main reason given for the delay is that, following an evaluation, the pilot system proved to be unsatisfactory due to technical difficulties. The National Patient Safety Agency therefore considered it should not be rolled out to the whole of the UK. The scale of the proposed replacement system meant that the Agency had to obtain Treasury approval for its full Business Case (February 2003) before re-tendering. This further contributed to the delays. The Department did not accept that it had set unrealistic target dates for the implementation, but believed that it was better to make sure that it was getting quality and value for money for a system that would work for all 607 NHS trusts.<sup>14</sup>

14. The motivation for developing the e-Form was the need to have a system that enabled those who might not report through their local systems still to report to the Agency. By January 2006, it had received 2,914 e-Form reports, 9% of which were from doctors, a higher percentage than from the trust reporting systems. Whilst encouraging better compliance by this hard to reach group, the lessons learned are constrained by being unable to trace these reports to the original event.<sup>15</sup>

15. The National Patient Safety Agency developed a bespoke taxonomy for reporting incidents in England and Wales rather than adopting existing taxonomies in use in other parts of the world. It judged that the NHS required a description and classification that covered all health care sectors, including mental health and primary care, and this comprehensive taxonomy did not exist anywhere else. Two-thirds of trusts reported that the taxonomy for their sector was not specific enough for their purposes and were continuing to use their own for local reporting. Meanwhile, the World Health Organisation is developing an international taxonomy to which the NHS is expected to sign up.<sup>16</sup>

16. Each trust had to map their taxonomy on to that provided by the Agency, which created problems for 82% of trusts and led to some of the delays. By January 2006 all trusts had started to report regularly to the National Reporting and Learning System. Some trusts are however questioning the value of submitting data to the National Reporting and Learning System given the lack of feedback on solutions to specific patient safety incidents. The Department nevertheless believes that the National Reporting and Learning System is one of the main achievements of the National Patient Safety Agency.<sup>17</sup>

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13 C&AG’s Report, para 2.31; Qq 11, 140, 142

14 C&AG’s Report, para 2.33; Qq 11, 70, 78–79

15 Qq 13, 58–60

16 C&AG’s Report, Executive Summary para 19; Qq 62–65, 107–109

17 C&AG’s Report, Executive Summary paras 19, 28; Qq 2, 7, 15, 86

17. In relation to its primary role of providing feedback and maximising learning in the NHS, the National Patient Safety Agency has issued 15 solutions since 2002, which it expects trusts across England to implement. These include the national 'cleanyourhands' campaign and the standardisation of crash call numbers. It has issued an alert on infusion devices, which it estimates has reduced the risk of incorrect use by half; and recommended that undiluted potassium chloride should not be kept on wards.

### 3 What more needs to be done?

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18. The Committee considered it unsatisfactory that one in ten patients admitted to hospital is unintentionally harmed. The Department agreed that based on experiences in other high risk industries such as aviation, year on year improvements (to 1 in 15 or 1 in 20) could in time be achieved. However, like these other industries it could take the NHS a decade or more systematically to improve safety to such a standard. More immediate improvements should be achievable through the advent of the electronic patient record which is expected to reduce the number of incidents due to lost, poor or fragmented clinical information and improve drug dispensing, by eliminating the risk of misinterpretation of clinicians' handwriting.<sup>18</sup>

19. England is one of the few countries to have a nationwide approach to patient safety. It has national structures in place such as: a comprehensive quality framework; national inspectorates; bodies to help embed an open and fair culture; systems for reporting and learning; and national training curricula. This approach should help to identify risks that might otherwise have been missed and enable solutions to be developed in a systematic, cost-effective way that avoids duplication. However, the National Patient Safety Agency has been slow to develop and disseminate solutions to NHS trusts. Given that enhancements to patient safety can only happen at trust level, at the interface between healthcare workers and patients, any national solutions need to be seen by trusts to be effective.<sup>19</sup>

20. Some trusts still have some way to go to establish an open and fair culture, including developing more effective team working and better communication with patients. Trusts also need to improve routine feedback of data and findings on incidents to staff, with time for reflection and learning. In those trusts where these principles are well-established, there are good examples of local learning to improve patient safety, some of which have been demonstrated to be cost-effective. The National Patient Safety Agency has not sought to capture these local examples and doubts amongst healthcare workers remain as to whether the Agency can make a difference.<sup>20</sup>

21. The National Reporting and Learning System now receives 60,000 reports a month, proportionately greater than any other system in the world, significantly increasing the level of information the NHS has on the number and extent of patient safety incidents. The National Patient Safety Agency has yet to demonstrate that it is using this information and knowledge effectively to change healthcare practices rather than simply collecting statistics.<sup>21</sup>

22. The Department concurred that, although the National Patient Safety Agency had produced a number of specific solutions, the learning system was not yet working as well as it could. Trusts generally perceive that the Agency has failed to maximise learning because

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18 Qq 22, 24–27, 95–97

19 Qq 3, 77, 90–91, 116

20 C&AG's Report, Executive Summary para 6, paras 3.10–3.11 and Case Examples 6–7; Q 119

21 Qq 2–3, 7

it has not provided feedback quickly and regularly. The agreement of the Department to publish quarterly reports from the Patient Safety Observatory (an arm of the Agency which quantifies, characterises and prioritises patient safety issues) will go some way to address this, particularly once information from the reporting system is brought together with information from other systems recording complaints and litigation.<sup>22</sup>

23. The Agency will have to analyse nearly one million incident reports a year, two-thirds of which may not have caused any actual harm to the patient. The collection of risk based, aggregate data, would allow the Agency to prioritise more effectively, for example by gathering details on the number of deaths and serious injury resulting from patient safety incidents. This would also enable the Agency to focus on high impact solutions, such as new methods for dispensing medication to reduce medication errors (25% of all reported incidents).<sup>23</sup>

24. The National Reporting and Learning System has increased rather than reduced the complexity of NHS reporting, and trusts still have to report the same incidents to more than one organisation (for example, medical devices errors are also reported to the Medicines and Healthcare Products Regulatory Agency). There is a need for greater co-ordination between NHS organisations. The Department's National Programme for Information Technology in the NHS is intended to create a single portal for reporting with data then passed onto the relevant stakeholder.<sup>24</sup>

25. Learning lessons is most likely to come from the information on contributory factors and currently only a small percentage of reports to the National Patient Safety Agency contain this information in either the data or free text fields. The National Patient Safety Agency would like to see more trusts providing this information. It was working with NHS Connecting for Health to explore making contributory factors a mandatory field in the national specification for risk management systems.<sup>25</sup>

26. Independent providers of NHS funded care are covered by the Healthcare Commission's inspection process, which requires them to comply with National Minimum Standards, including having an incident reporting system. Currently, however, independent providers are not obliged to share that data with any NHS body. Service Level Agreements should ensure that such data on patient safety incidents is made public. Indeed, if GPs and their patients are to be able to make informed choices between providers, as part of the new patient choice agenda, there will be a need for robust comparable data on all providers.<sup>26</sup>

27. For this reporting and learning to have a demonstrable impact on the experience of patients, the level of data submission and implementation of safety alerts and guidance at trust level needs to be monitored. Trusts self-certify that they have implemented safety solutions from the Safety Alert Broadcast System (a Departmental system for notifying

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22 Qq 26, 86

23 Qq 117, 133

24 Qq 19, 112–114

25 Qq 32–33, 66–69, 87

26 Qq 35, 38–41, 43–46, 50–53

trusts of matters that require attention) and strategic health authorities monitor this data. However, actual compliance with this guidance is not audited.<sup>27</sup>

28. Worldwide there are few examples of where reductions in risk can be quantified and attributed to particular interventions. Few trusts have quantified the cost of specific patient safety incidents and the National Patient Safety Agency has only produced one template business case for trusts to customise to argue for investment in safety solutions. More information on the cost-effectiveness of solutions would enable trusts to prioritise scarce resources more effectively.<sup>28</sup>

29. The NHS needs to be open in its dealings with patients involved in safety incidents. Patients expect an apology, a full explanation, to be involved in an investigation, and to help determine what actions might prevent future harm. Australia and the Veterans' Health Service of the United States of America have had policies advocating these principles for a number of years, and the National Patient Safety Agency's guidance *Being Open*, issued in September 2005, has drawn on their experiences. The Agency has also launched teaching materials to allow trusts to develop appropriate local policies and give clinicians practice in informing patients about incidents. The Chief Medical Officer has produced a report on reforms to the medical litigation system, *Making Amends*, and there is a proposed new Bill on this.<sup>29</sup>

30. The Department, through its former agency, the National Clinical Assessment Authority, has made some progress in providing support to poorly performing doctors and in resolving long running suspensions, whilst ensuring patients are protected. The expanded role of the National Patient Safety Agency now covers these responsibilities, but is still only providing support to doctors and dentists. A similar service should be available to nursing and other clinical staff. Whilst the Chief Nursing Officer and the National Patient Safety Agency have sought to strengthen local systems which deal with poor performance of this much larger group of staff, all staff need equal access to some degree of independent support.

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27 C&AG's Report, paras 3.25–3.28; Q 98

28 Qq 89, 94

29 Qq 29–30, 61, 139

# Formal minutes

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**Wednesday 14 June 2006**

Members present:

Mr Edward Leigh, in the Chair

Mr Richard Bacon

Greg Clark

Mr David Curry

Helen Goodman

Dr John Pugh

Kitty Ussher

A draft Report (A safer place for patients: learning to improve patient safety), proposed by the Chairman, brought up and read.

*Ordered*, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 30 read and agreed to.

Summary read and agreed to.

Conclusions and recommendations read and agreed to.

*Resolved*, That the Report be the Fifty-first Report of the Committee to the House.

*Ordered*, That the Chairman make the Report to the House.

*Ordered*, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned until Monday 19 June at 4.30 pm.]

## Witnesses

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**Monday 16 January 2006**

*Page*

**Sir Nigel Crisp KCB, Professor Sir Liam Donaldson KCB**, Department of Health,  
and **Ms Susan Williams**, National Patient Safety Agency

Ev 1

## List of written evidence

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Department of Health

Ev 18

National Audit Office

Ev 21

## List of Reports from the Committee of Public Accounts Session 2005–06

First Report	Managing National Lottery Distribution Fund balances	HC 408 ( <i>Cm 6712</i> )
Second Report	The regeneration of the Millennium Dome and associated land	HC 409 ( <i>Cm 6689</i> )
Third Report	Ministry of Defence: Major Projects Report 2004	HC 410 ( <i>Cm 6712</i> )
Fourth Report	Fraud and error in benefit expenditure	HC 411 ( <i>Cm 6728</i> )
Fifth Report	Inland Revenue: Tax Credits and deleted tax cases	HC 412 ( <i>Cm 6689</i> )
Sixth Report	Department of Trade and Industry: Renewable energy	HC 413 ( <i>Cm 6689</i> )
Seventh Report	The use of operating theatres in the Northern Ireland Health and Personal Social Services	HC 414 ( <i>Cm 6699</i> )
Eighth Report	Navan Centre	HC 415 ( <i>Cm 6699</i> )
Ninth Report	Foot and Mouth Disease: applying the lessons	HC 563 ( <i>Cm 6728</i> )
Tenth Report	Jobskills	HC 564 ( <i>Cm 6724</i> )
Eleventh Report	Local Management of Schools	HC 565 ( <i>Cm 6724</i> )
Twelfth Report	Helping those in financial hardship: the running of the Social Fund	HC 601 ( <i>Cm 6728</i> )
Thirteenth Report	The Office of the Deputy Prime Minister: Tackling homelessness	HC 653 ( <i>Cm 6743</i> )
Fourteenth Report	Energywatch and Postwatch	HC 654 ( <i>Cm 6743</i> )
Fifteenth Report	HM Customs and Excise Standard Report 2003–04	HC 695 ( <i>Cm 6743</i> )
Sixteenth Report	Home Office: Reducing vehicle crime	HC 696 ( <i>Cm 6743</i> )
Seventeenth Report	Achieving value for money in the delivery of public services	HC 742 ( <i>Cm 6743</i> )
First Special Report	The BBC's investment in Freeview: The response of the BBC Governors to the Committee's Third Report of Session 2004–05	HC 750 ( <i>N/A</i> )
Eighteenth Report	Department for Education and Skills: Improving school attendance in England	HC 789 ( <i>Cm 6766</i> )
Nineteenth Report	Department of Health: Tackling cancer: improving the patient journey	HC 790 ( <i>Cm 6766</i> )
Twentieth Report	The NHS Cancer Plan: a progress report	HC 791 ( <i>Cm 6766</i> )
Twenty-first Report	Skills for Life: Improving adult literacy and numeracy	HC 792 ( <i>Cm 6766</i> )
Twenty-second Report	Maintaining and improving Britain's railway stations	HC 535 ( <i>Cm 6775</i> )
Twenty-third Report	Filing of income tax self assessment returns	HC 681 ( <i>Cm 6775</i> )
Twenty-fourth Report	The BBC's White City 2 development	HC 652
Twenty-fifth Report	Securing strategic leadership in the learning and skills sector	HC 602 ( <i>Cm 6775</i> )
Twenty-sixth Report	Assessing and reporting military readiness	HC 667 ( <i>Cm 6775</i> )
Twenty-seventh Report	Lost in translation? Responding to the challenges of European law	HC 590 ( <i>Cm 6775</i> )
Twenty-eighth Report	Extending access to learning through technology: Ufi and the learndirect service	HC 706 ( <i>Cm 6775</i> )
Twenty-ninth Report	Excess Votes 2004–05	HC 916 ( <i>N/A</i> )

Thirtieth Report	Excess Votes (Northern Ireland) 2004–05	HC 917 (N/A)
Thirty-first Report	Northern Ireland's Waste Management Strategy	HC 741
Thirty-second Report	Working with the voluntary sector	HC 717 (Cm 6789)
Thirty-third Report	The Royal Parks and the Diana, Princess of Wales Memorial Fountain	HC 644 (Cm 6789)
Thirty-fourth Report	Returning failed asylum applicants	HC 620 (Cm 6863)
Thirty-fifth Report	The refinancing of the Norfolk and Norwich PFI Hospital	HC 694
Thirty-sixth Report	Tackling the complexity of the benefits system	HC 765 (Cm 6863)
Thirty-seventh Report	Inland Revenue Standard Report: New Tax Credits	HC 782 (Cm 6863)
Thirty-eighth Report	Channel Tunnel Rail Link	HC 727 (Cm 6863)
Thirty-ninth Report	Consular services to British nationals	HC 813 (Cm 6863)
Fortieth Report	Environment Agency: Efficiency in water resource management	HC 749
Forty-first Report	The South Eastern Passenger Rail Franchise	HC 770
Forty-second Report	Enforcing competition in markets	HC 841
Forty-third Report	Delivery chain analysis for bus services in England	HC 851
Forty-fourth Report	National Offender Management Service: dealing with increased numbers in custody	HC 788
Forty-fifth Report	Employers' perspectives on improving skills for employment	HC 862
Forty-sixth Report	Governance issues in the Department of Enterprise, Trade and Investment's former Local Enterprise Development Unit	HC 918
Second Special Report	The BBC's White City 2 development: The response of the BBC Governors to the Committee's Twenty-fourth Report of Session 2005–06	HC 1139 (N/A)
Forty-seventh Report	NHS Local Improvement Finance Trusts	HC 562
Forty-eighth Report	HM Customs and Excise: Standard Report 2004–05	HC 874
Forty-ninth Report	Corporation Tax: companies managed by HM Revenue and Customs' Area Offices	HC 967
Fiftieth Report	Ministry of Defence: Major Projects Report 2005	HC 889
Fifty-first Report	A safer place for patients: learning to improve patient safety	HC 831

The reference number of the Treasury Minute to each Report is printed in brackets after the HC printing number

# Oral evidence

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## Taken before the Committee of Public Accounts

on Monday 16 January 2006

Members present:

Mr Edward Leigh, in the Chair

Mr Richard Bacon  
Greg Clark  
Mr Sadiq Khan  
Mr Austin Mitchell

Jon Trickett  
Kitty Ussher  
Mr Alan Williams

**Sir John Bourn KCB**, Comptroller and Auditor General, National Audit Office, was in attendance and gave oral evidence.

**Mr Marius Gallaher**, Alternate Treasury Officer of Accounts, HM Treasury, was in attendance.

### REPORT BY THE COMPTROLLER AND AUDITOR GENERAL

#### A Safer Place for Patients: Learning to Improve Patient Safety (HC 456)

*Witnesses:* **Sir Nigel Crisp KCB**, Permanent Secretary and Chief Executive of the NHS, **Professor Sir Liam Donaldson KCB**, Chief Medical Officer, the Department of Health; and **Ms Susan Williams**, Joint Chief Executive, National Patient Safety Agency, gave evidence.

**Q1 Chairman:** Welcome to the Committee of Public Accounts where today we are looking at the Comptroller and Auditor General's Report on *A Safer Place for Patients: Learning to Improve Patient Safety*. We are joined once again by Sir Nigel Crisp, who is the Permanent Secretary and Chief Executive of the NHS. Would you like to introduce your team as usual, Sir Nigel?

**Sir Nigel Crisp:** Thank you, Chairman. Firstly, the Chief Medical Officer, Sir Liam Donaldson. We are also joined by Susan Williams, who is the Joint Chief Executive of the National Patient Safety Agency.

**Q2 Chairman:** Thank you very much. Perhaps we can start by getting an idea of the scale of the problem. The relevant figure is figure one, which you can find on page one. There is also reference in paragraphs 2.10 and 2.11 on page 27. You have got rather a wide range. The NAO estimate that at least 2,000 patients died in 2004–05 as a result of a safety incident. The NHS incidents range from 840 to this figure of 72,000 which you can find at paragraph 2.10. How can you expect to address this problem when these estimates range so widely?

**Sir Nigel Crisp:** Obviously that is an extremely fair point and it is why so much effort has been put into the last few years to get a much better understanding of what is actually happening, both in terms of the number of incidents and the type of incidents. I can say that the current rate is we are getting about 60,000 reports a month now, which is an update on these figures just for the last month. Also, literally now, we have got 100% of NHS organisations in England and Wales as part of the reporting system. We are bringing the reporting system together but as you know, and as the Report makes clear, there are

cultural issues here about making sure that people report things and how they report them and it is very important that we get the definitions right. What I think I am saying in response to your question is this is the latest stage of knowledge, it is moving quite fast, we are getting more information, and we will be in a better position in due course to get a closer picture on it.<sup>1</sup>

**Q3 Chairman:** We can pursue that during the afternoon. Can we get an idea of international comparisons. This is dealt with on page 67 of the Report, appendix four. We have got a high and rising incidence of unintentional harm to patients. Looking at these figures, if you compare the figure for London, England, particularly with some states in America and in Canada, I wonder whether the NHS is becoming a less safe place than some other systems.

**Sir Nigel Crisp:** May I just make one or two comments and then perhaps I could turn to Sir Liam who is much more expert on this. One observes from that table the range of different years that relate to that. What we do know from the National Reporting and Learning System that we have got is that we are now seeing as many reports proportionately as the best in the world, so we are getting a figure that is as good as the best in the world and maybe slightly ahead of them. We are getting a much better understanding of the issues and we have got the data. Also, we have got a truly national approach to patient safety which I think is not true

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elsewhere. The architect of much of that was actually Sir Liam and I think it would be useful if he could say something about the international comparisons.

**Q4 Chairman:** Certainly.

**Professor Sir Liam Donaldson:** Thank you, Chairman. A lot of the data are derived from surveys rather than from established reporting systems and, on the whole, they have been surveys of medical records carried out in hospitals. They have been undertaken using broadly similar methodologies. A lot of the earlier studies showed lower rates of prevalence of what is usually internationally called medical error. Experts that I have talked to, and I have talked to them very extensively worldwide, use a ballpark figure of 10% of hospital admissions.

**Q5 Chairman:** So you reckon we are about average?

**Professor Sir Liam Donaldson:** I do indeed. If you want to go into it in more depth, I think there are some reasons why some of the earlier US figures—

**Q6 Chairman:** I think we need to have a note on that so we can get it right in our Report.<sup>2</sup> Obviously things have moved on. Sir Nigel, you are spending about £15 million annually on the National Patient Safety Agency, is that right?

**Sir Nigel Crisp:** Something of that order, yes.

**Q7 Chairman:** Just give me four concrete achievements of this Agency so that we can have an idea of whether it is providing us with value for money.

**Sir Nigel Crisp:** I think the first one is the National Reporting System which is now receiving around 60,000 reports a month. The second area would be if I can take two different patient safety solutions that have come from there. One was related to the infusion devices which was identified as a problem but since then safer practice notices were issued and opportunities for high risk error associated with use of the infusion pumps have been reduced by half and there are some significant, but we cannot precisely quantify yet, cost savings that are coming from that. Another one would be the alert on the safe storage and handling of potassium chloride, which was implemented across the NHS.

**Q8 Chairman:** You mentioned that but I am told, in fact, that warning was given four years after an alert was issued in the US about that particular issue of potassium chloride.

**Sir Nigel Crisp:** Can I defer to one of my colleagues to make a response to that.

**Professor Sir Liam Donaldson:** There have been alerts issued in other countries and some of them did precede the NPSA's alert. The NPSA's alert arose directly from analysis of the data coming from the pilot phase.

**Q9 Chairman:** Complete your answer, Sir Nigel.

**Sir Nigel Crisp:** If I mention two others plus one general point. The 'cleanyourhands' safety alert and campaign has begun to have a really significant impact now. That has also come from there. The other point that is here is, as the Report itself says, there is an improving safety culture in the NHS. It needs to improve further, we would be absolutely clear about that from the Department, but the NPSA has played a significant role in that.

*The Committee suspended from 4.39pm to 4.45pm for a division in the House.*

**Q10 Chairman:** Can we now look at the National Reporting and Learning System, if you could look at paragraph 2.34 on page 35.

**Sir Nigel Crisp:** Yes.

**Q11 Chairman:** It took two years longer to set up, did it not, and it cost over £1 million more than planned. Was this value for money?

**Sir Nigel Crisp:** The reason for the delay, which was two years, as you say, was that it was piloted, so there was a pilot system which was put in, which was a genuine pilot, from which some learning was taken but the NPSA judged this to be unsatisfactory and, therefore, there was an in house build, following an options appraisal, made which led to the system we have got now. If I can put it like this, it was actually an attempt to make sure that we were getting quality and value for money that led to the delay, making sure we worked it through. You are right that the original business plan was £9 million and something on a lifetime cost and the revised business plan, which came in as a result of some further review, took it up to £10 million and something, so approximately £1 million. It was worked through very clearly on both of those business plans with Treasury signing off the original business plan, as was appropriate, and so on.

**Q12 Chairman:** There are certain parts that are worrying. For instance, an anonymous e-reporting system was set up, and that is mentioned in paragraph 2.36, but I was told that you have only received 108 emails, is that right?

**Sir Nigel Crisp:** Could I hand that one to Sue Williams.

**Q13 Chairman:** 108 emails nationally is nothing, it is what we get as individual Members of Parliament every other day.

**Ms Williams:** We launched the www service later than the main reporting system as we wanted to try to make sure that as many trusts were connected so we did not undermine trust reporting. We now have got 2,914 reports in from that route. Very interestingly, 9% of those reports are coming in now from medical staff. That is a higher percentage from normal reporting systems. It is clearly attracting a group of staff as a safety net.

**Sir Nigel Crisp:** Can I just add to that. There are two points. One is this was a safeguard system to make sure that we could pick up whistle blowing, if you

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like, the people who might not wish to report through the standard system. Secondly, the relatively small number is probably a reasonable indication that people are willing to use the main system. That is the thinking behind that and, as you see, it has now picked up in terms of numbers.

**Q14 Chairman:** In your first answer to me you said that all the trusts are now using the National Reporting and Learning System but at the time this Report was written 35 trusts were still not using it. That is right, is it not?

**Sir Nigel Crisp:** Yes.

**Q15 Chairman:** So obviously something has happened. What has been happening? Have you been running around desperately to make sure that all the trusts are using it in recent months?

**Sir Nigel Crisp:** Again, can I pass that to the NPSA.

**Ms Williams:** We have a team of 28 patient safety managers who work right across the country and they have been working with local trusts to encourage their connection to the system and the receipt of reports.

**Q16 Chairman:** I wonder whether that has had anything to do with the fact that this hearing is taking place. Here is this Report being published on Thursday 3 November, 35 trusts were not using it, and suddenly here we are meeting in the middle of January and they are all using it. That is very good, we like to feel we have some influence.

**Sir Nigel Crisp:** May I just say, that does mean it was 95% before, so it was very sensible of us to have wiped up the 5%.

**Q17 Chairman:** Fair enough. We had a PAC recommendation in December 2003 that the work of the National Clinical Assessment Service be extended to cover nurses and other clinical staff. The Treasury Minute said that was accepted by the Government but nothing has happened yet. When we make these recommendations and they are accepted by the Government it is nice if they are carried out.

**Sir Nigel Crisp:** I might ask Sir Liam to step in in a moment. Where we are in this is a much bigger group of staff, about half a million staff, as opposed to the relatively smaller number of doctors. We have a group led by the Chief Nursing Officer which is working on this with the NPSA to try and develop a system which will allow for issues more to be dealt with locally than nationally. What we do not want to do is to draw every problem up nationally but to make sure that we have got the right principles being applied locally that where there are issues of individual staff—

**Q18 Chairman:** So this is going to happen?

**Sir Nigel Crisp:** Something will come out in the spring.

**Q19 Chairman:** If you look at page three, this is the stakeholders in patient safety. If you look at that, Sir Nigel, at these very large numbers. This is figure two,

page three. I just wonder whether you are making enough progress in rationalising matters. We have this very high level of incidents, although there is some doubt about that, we have this extraordinarily complex system, whereas what we really want as patients is simply zero tolerance on this issue, is it not, and a lack of confusion?

**Sir Nigel Crisp:** I completely agree, what that shows is there are a lot of stakeholders. The biggest issue on that is are they all making demands on the system to get reporting, which is picked up elsewhere in the document later on. What we are trying to do at the moment, and I know that the NPSA has got somebody seconded to our Connecting for Health programme, is to create a single portal for people to report so that broadly the same information that somebody may be reporting in a local primary care setting or acute hospital is made available to the relevant stakeholders. If you look at that list clearly there are people with very clear statutory responsibilities, like the coroner and so on. There will not be a complete ability to share it but we think we can do better than we are doing at the moment and that is what we are trying to do.

**Q20 Chairman:** Lastly, Sir Nigel, did you see the front page of the *Daily Telegraph* today? “£235,000 lavished on slipper safety advice. A £235,000 scheme advising the elderly on how to wear slippers is among the array of examples of wasteful government spending in this area. They include £40,000 spending by the NHS on a 46-word patient experience definition that required two £8,000 workshops, £4,000 of public meetings, two £1,600 meetings with children, three £600 in-depth interviews. Among the aspirations established by the exercise was that patients wished to be treated with both honesty, respect and dignity”, which we would have hoped would be obvious.

**Sir Nigel Crisp:** I have not seen the *Daily Telegraph*.

**Q21 Chairman:** On slipper safety.

**Sir Nigel Crisp:** I do note from the figures in this Report that the biggest area of reports of incidents is people falling. I cannot remember where it is in the document. It is something like 31.5% are about falls. We do know that in areas where people have set up what are called falls clinics—they are as simple as that—we are seeing some improvement in the reduction of fractured femurs and so on. Whether that particular expenditure was justified or not, reducing falls amongst elder people is undoubtedly justified.

**Q22 Mr Khan:** Can I say how reassured I am that you do not read the *Daily Telegraph*. I am pleased to hear that. I am afraid I have got to leave shortly for another meeting, so apologies, no discourtesy is intended. My first question is do you think it is realistic and reasonable for one in 10 patients who are admitted to NHS hospitals to be unintentionally harmed?

**Sir Nigel Crisp:** No, I do not. As a patient, this is something I want to know that we take extremely seriously.

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**Q23 Mr Khan:** What are the experiences of other countries?

**Sir Nigel Crisp:** Broadly similar. I think it is worth drawing out, as it does in this Report, that two-thirds of that 10% do not experience any harm, so we are lumping everything together in that. Again, Sir Liam is the international expert on this and he could talk more about that.

**Q24 Mr Khan:** What I am interested in is 10% is not realistic and it should be lower—the obvious thing is to say it should be zero of course—if you were to come back here in a year's time or 24 months' time, what would that figure be?

**Sir Nigel Crisp:** I doubt in that sort of period that it would shift, but I do not like using an argument that we are just as bad as everyone else.

**Q25 Mr Khan:** How long do patients have to wait before they see an improvement that is noticeable?

**Sir Nigel Crisp:** You will see certain categories where we have got improvements. I could have said in response to an earlier comment that the National Patient Safety Agency has sent out 15 safety alerts in the last three years about specific devices or use of drugs or whatever; and that compares with 10 in America over the same period, for example. We are actively trying to focus down on individual issues and make sure that those particular sorts of incidents never reoccur. We have got the IT system. A lot of these incidents were about slightly wrong levels of medication and when we are not relying on people's handwriting we will get better at that as well, so you will see some changes.

**Q26 Mr Khan:** How soon before we see changes on the ground?

**Professor Sir Liam Donaldson:** Could I add a comment? I think in most developed countries the ballpark figure is similar. The comparison should be with other high risk industries, like the airline industry who have systematically improved safety. It has taken several decades or more to get to where they are, in fact even longer than that in some industries, but we have some of the key ingredients in place that have been shown from evidence from other industries to work. We are seeing cultural change which is probably the most important thing, more safety awareness in local services, and that is acknowledged in the Report. We are seeing more reporting and analysis of reports, which was also a way in which the airline industry changed. We are seeing specific solutions coming through to reduce risk. Those are not working as well as they could be yet but, as Sir Nigel said, there are more of them coming through and certainly the advent of the electronic patient record will benefit safety of medication which accounts for 25% of the harm worldwide, medication errors, and it will also reduce some of the problems that result from poor communication and fragmented clinical information.

**Q27 Mr Khan:** So a noticeable change a decade from now?

**Professor Sir Liam Donaldson:** Absolutely, yes, but with incremental change over that period.

**Q28 Mr Khan:** One of the things you referred to was the culture. In the context of enhancing the safety culture within NHS trusts, there are comments made in the Report about having an open and fair employer so that staff feel confident coming forward. Can I ask you what further actions you expect the NPSA to take to improve the culture in the NHS so that staff feel they have an open and fair employer?

**Professor Sir Liam Donaldson:** I think they have already put out guidance to good practice that staff should not be suspended unless there is evidence of negligence or careless conduct. On the majority of occasions when something goes wrong there is an error but it is a failure provoked by weak systems supporting the practitioner concerned, so just by careful monitoring. We do live in a blame culture society, as is the case in many Western countries, where scapegoats are looked for and individuals are blamed for mistakes but as we have seen in other industries, like the airline industry, that blame culture can be rolled back but it requires effort not just within the service concerned but by society as a whole and in particular the media.

**Q29 Mr Khan:** In particular, in your answer a knock-on effect that will have on clinical negligence cases is if you are admitting your mistakes that may have an impact on the number of cases that are settled.

**Ms Williams:** The programme we have to support a culture of change is we have trained 8,000 staff in root cause analysis, which is a particular technique which seeks to look at the contributory factors that lie behind an incident which starts to move people away from individual blame. At our conference next month we are launching a cultural assessment tool so that trusts themselves, whether at unit team level or strategic health authority level, can assess the level of maturity against a well recognised and used tool in other industries. We have trained and worked with 113 boards to talk through the issues of open and fair culture. We have issued a chief exec checklist so that chief execs themselves know the role that they can play to promote safety. Also, we have run leadership courses through the lens of patient safety to introduce them to some of these concepts. In terms of your last question, I am sorry I lost the—

**Q30 Mr Khan:** The impact on settlements in cases.

**Ms Williams:** Just recently we issued a *Being open* policy and teaching materials. This involves apologising and giving a full explanation involving the patient and their relatives in working through what actions might prevent harm in the future. We built that policy from experience both in Australia but particularly in Veterans' Health Services in the USA where they have run this policy for a number of years and their negligence bill has not increased during this time.

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**Q31 Mr Khan:** At the beginning of your answer you referred to your 8,000 staff who have been trained on the forms. How will the NPSA be able to identify learning when it says in paragraph 2.38 that trusts “are not required to provide information on contributory factors”?

**Ms Williams:** A number of trusts are using the form that—

**Q32 Mr Khan:** They are not required to, are they?

**Ms Williams:** Not at the moment because we are reliant on seven or eight commercial vendors and not all of those systems collect contributory factors. The numbers where we are getting this information is increasing. What we would like to see over time, as people become familiar with these terms—these are very new ways of looking at incidents—as trusts become more familiar is their internal forms changing.

**Q33 Mr Khan:** Do you envisage it being a requirement to provide those?

**Ms Williams:** I think in time, yes, it will be.

**Q34 Mr Khan:** This is probably a question for Sir Liam. Most countries favour a confidential rather than anonymous service for reporting because it means that you can learn from the information you are given. Why is the National Reporting and Learning System that we have anonymous?

**Professor Sir Liam Donaldson:** Only one aspect of it is anonymous. The confidentiality code can be broken in circumstances where there is a very serious cluster of cases that needs to be investigated further. By and large, the majority of reports are made through local risk managers, the clinicians giving their reports to the local risk managers. They are being open about it anyway. It is important to emphasise that a lot of learning needs to take place at local level, it is not just a case of looking at reports at national level, those incidents need to be used at local level to introduce safer systems in the hospital.

**Q35 Jon Trickett:** I want to reflect on patient choice since we are now offering a choice of hospitals to patients. What information is provided to patients about the level of accidents, say per thousand staff, so they choose which hospital they would prefer to go to?

**Ms Williams:** At the moment there are a number of trust boards who do put papers on their public part of the agenda which show the number of incidents by specialty and what action they are taking as a result. The work that we have done with groups of patients to discuss this issue to feed into the patient choice agenda is the issue for us is that more reports is a sign of a healthy environment in which incidents are raised and action can be taken and, therefore, it seems more counterintuitive but more reports is a good thing for patients to be looking for. In fact, to choose a hospital where there were very few reports might be a concern because it might show that there might be a level of cover-up.

**Q36 Jon Trickett:** Does the GP provide to the patient the number of accidents in the four hospitals which are being offered to the patients?

**Sir Nigel Crisp:** No. The two things that the patients will get are the MRSA rate, which is one of the issues here, and that is published by the hospital, and the second thing that is also available to patients is the Healthcare Commission’s Report on the hospital. We do not have a figure of accidents per so many staff.

**Q37 Jon Trickett:** I will ask you about the two tables in here in a second. What monitoring do we do? If I go to my GP and I am referred to three NHS trusts and a BUPA hospital and I ask what information he or she has about the number of accidents across the four sites, is that information available to him or her?

**Sir Nigel Crisp:** There is not information that is systematically available about accidents across sites. There is about the things that we collect and publish, and I deliberately say MRSA and I do deliberately pick out the Health Care Commission’s Report which will be made public. Those are in the public domain. As you know from the earlier discussion and the points that Ms Williams has just been making, there is not a simple definition of what are accidents as opposed to anything else.

**Q38 Jon Trickett:** You have signed the paper off. Do we collect information about hospitals in the independent sector, the number of accidents?

**Sir Nigel Crisp:** We do not. What we are doing with the NPSA is first of all starting with the hospitals physically within the NHS with the intention of then moving on to deal with the independent sector of whatever sort.

**Q39 Jon Trickett:** Do you have statutory powers to receive the information from the independent sector?

**Sir Nigel Crisp:** The Healthcare Commission does.

**Q40 Jon Trickett:** The NPSA, does your remit run into the independent sector hospitals?

**Ms Williams:** Our remit extends to wherever NHS care is funded and, therefore, clearly the independent sector is a vast area and—

**Q41 Jon Trickett:** Are you collecting information from, say, BUPA hospitals?

**Ms Williams:** Not at the moment. We are concentrating on getting all the NHS trusts reporting.

**Q42 Jon Trickett:** Now we are committed, are we not, to 15% of all operations going into the independent sector?

**Sir Nigel Crisp:** No, we are not actually. That is a quotation from Mr Reid which was up to 15%.

**Q43 Jon Trickett:** We are committed to a number of NHS operations being commissioned in the independent sector, whatever the figure is. We have

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no idea at all how many accidents have taken place in the various hospitals which are being offered by the GPs, is that correct?

**Sir Nigel Crisp:** We do not have the same system in place yet in terms of direct reporting.

**Q44 Jon Trickett:** Would it not be a good idea for the local health authorities to find out how many accidents take place in independent sector hospitals before they are offered to patients as one of the four choices?

**Sir Nigel Crisp:** In the contracts with the independent sector agencies we do have requirements about what we call clinical governance, which is about reporting and how they manage patient incidents. It is not the same mechanism.

**Q45 Jon Trickett:** You have no idea how many accidents are taking place at Methley Park, which is the local BUPA hospital in my patch?

**Sir Nigel Crisp:** I think that is true. I do not know whether either of my colleagues know.

**Q46 Jon Trickett:** You do not have any idea at all? On the ISTCs, the independent sector treatment centres, are we monitoring those?

**Sir Nigel Crisp:** Not through the same system. As I was saying, we have contracts with the individual organisations which have certain requirements about clinical governance in them and about the reporting of incidents, how they are managed and who is overseeing them and so on. That is something we have got under review.

**Q47 Jon Trickett:** Let me ask you another question because I have just come from a meeting with my local chief executive who tells me he is about to hand a lot of staff over to the PFI partner for the local hospital. They will be working in an NHS hospital but it is a PFI hospital. Those porters, electricians, joiners, domestic cleaners and all those kinds of staff are not going to be employed by the NHS. Do they come under the reporting mechanisms which you have been talking about this afternoon?

**Sir Nigel Crisp:** Yes, I think they do.

**Ms Williams:** There are a number of PFI hospitals which are reporting through to us. If I may add that the larger private sector, independent sector hospitals very often do have their own reporting systems and we are in discussion with them about how they might link through to the National Reporting and Learning System.

**Q48 Jon Trickett:** You have given me two answers. Let me just deal with the second one and come back to the first. In terms of those staff who are employed by the PFI partner, are they obliged to report accidents in exactly the same way as NHS staff are?

**Sir Nigel Crisp:** In an NHS hospital.

**Q49 Jon Trickett:** Yes they are?

**Ms Williams:** Yes.

**Q50 Jon Trickett:** You then went back to the debate about the ISTCs. My understanding at the moment is that the ISTCs are not required to provide information. Whether or not they are doing, they are not required to, is that right?

**Ms Williams:** That is right.

**Q51 Jon Trickett:** Does your remit allow you to go into those hospitals at some point, it is just that you have not got round to it yet?

**Ms Williams:** We would like to develop an arrangement so that the independent sector, whether it is ISTCs or the larger hospitals, BUPA *et cetera*, can report incidents so that there is learning that can affect all patients.

**Q52 Jon Trickett:** So it is an aspiration, “we would like”?

**Ms Williams:** Yes.

**Q53 Jon Trickett:** I think that is profoundly unsatisfactory from the point of view of the patient, Sir Nigel. What do you think?

**Sir Nigel Crisp:** I understand the point, but that is why we have got the contracts with people and we have got what I have described as clinical governance arrangements to make sure that there is reporting to us of incidents so that we can investigate them, and why we have used our clinical governance team to go in and look at where we have had incidents reported.

**Q54 Jon Trickett:** Basically it is a lack of an even playing field between the NHS and the rest of the medical health sector, is it not? Can I just draw attention to table six on page 25 which shows this remarkable curve in terms of the number of incidents in each acute trust. The problem is it is not comparable to table five, which is the number of incidents per thousand staff. It is a very crude figure indeed, is it not? I might ask the NAO to produce it on the same basis. I will put that to Sir John.<sup>3</sup> The curve would be probably less since the smaller number of accidents might be taking place with only half a dozen staff or something.

**Sir John Bourn:** Right.

**Q55 Jon Trickett:** All these curves are all the same. Have you formed a view as to what correlation there is between the ones who have so few incidents and any sort of external factors which might govern a particular trust, or is it simply that self-reporting is not working, as I suspect?

**Sir Nigel Crisp:** You are quite right on the last point. These are reports of incidents rather than actual incidents, so there is some spread in what people are reporting. Very definitely we pick up on patterns but we need to pick up on patterns firstly at the local level and then nationally.

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<sup>3</sup> Report, p 9, Figure 2.

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**Ms Williams:** In a sense this is not unexpected given where we are in relation to the cultural issues that we were talking about earlier. Over time we would expect to see an increase in reporting rate across all of the NHS.

**Q56 Jon Trickett:** You would expect the curve to flatten out, would you not, and it is not over the two year period that we are looking at. Have you not asked the question of yourself in a way that you can report to us why there should be some trusts which are reporting almost no accidents at all?

**Ms Williams:** They have now but some trusts during this period did not have a centralised reporting system. What we found when we were developing the scheme, particularly in primary care and in the ambulance services, was there were some parts of the country where they were very reliant on the paper system and things were at a very early stage. There is nervousness amongst staff groups about reporting. Our role is to try to promote a culture where we see a year-on-year increase in reporting from all trusts.

**Q57 Jon Trickett:** My time is up but I wonder if I could ask the NAO to produce those figures I asked for and also whether there is a correlation between the number of stars which each trust has so we can see the curve for no star, one star, two star and three star trusts.

**Sir John Bourn:** I will produce that information.<sup>4</sup>

**Q58 Mr Bacon:** On page 34, paragraph 2.31, Sir Nigel, there is a reference to the fact that: "Healthcare organisations in other countries, having compared the merits of anonymous and confidential reporting, have generally opted for confidential reporting." This system opted for anonymous. Why do you think that was? Do you see yourselves moving towards a more open system?

**Sir Nigel Crisp:** I think this was the same point Sir Liam responded to a moment ago. I think we have got it confidential at a local level and anonymous at a national level. That is felt to be the right balance so that confidentiality can be handled and learned about at the local level whereas anonymous is the right level for us to be looking at the big patterns. Is there anything you want to add to that?

**Professor Sir Liam Donaldson:** I have already responded to part of that.

**Ms Williams:** We went for that de-identifier so that we do not carry names of clinicians or patients at a national level in the database. That is because what we are looking for is themes and trends, types of incidents, where we might be able to develop a system-wide intervention to prevent harm recurring to those particular groups of patients, therefore we do not need the identifying details about individual people at a national level.

**Q59 Mr Bacon:** I appreciate that you want to have as open reporting as you can about the facts and the themes and the trends and why people behave in

certain ways, but you still want to be able to take corrective and, if necessary, disciplinary action, do you not?

**Ms Williams:** Yes, and that will take place at the local level.

**Q60 Mr Bacon:** You are saying the nature of the report is such that there is a local identifier of who it is?

**Ms Williams:** Yes.

**Q61 Mr Bacon:** I think the very first committee meeting I attended of this Committee some years ago, certainly if not the first one of the very earliest, was on the NHS Litigation Authority. I remembered that meeting when reading this statement on page 55 where it says in paragraph 3.36: "the prevailing legal system does not encourage health professionals to be open after an adverse patient safety incident..." What have you done, Sir Nigel, to try to suggest policy changes to the prevailing legal system as it relates to medical error and as far as it relates to litigation since October 2001 when we had that hearing?

**Sir Nigel Crisp:** Some very specific things, but can I ask Sir Liam, who has been the architect of these, to address it.

**Professor Sir Liam Donaldson:** Apart from the measures that have been taken to encourage reporting and which have been pretty successful given the level of reporting that we have seen over the last couple of years. I also produced for the Government a report on reforming the medical litigation system called *Making Amends* which is about to work its way through the House towards a Bill. That firmly places emphasis on trying to get blame and retribution out of the litigation system, allowing patients, not just with small claims, to have compensation but also to ensure they have an apology, an explanation of what has happened and a report from the local health service telling them what action will be taken as a result of the incident that harmed them and how it might prevent harm to another patient. That is another strand of action which tries to improve the climate and stop us going down the American path of very confrontational and costly litigation.

**Q62 Mr Bacon:** This is a question for Ms Williams. It relates to paragraph 2.38 and the follow-up work to the *An Organisation with a Memory* report, and it says halfway down that paragraph: "Despite the existence of well-developed international incident classification, the National Patient Safety Agency decided to define its own taxonomy for national reporting and produce tailored versions for use in nine different healthcare settings." Why did you not follow the widely used international incident classification?

**Ms Williams:** We could not find any widely used international incident taxonomies.

**Q63 Mr Bacon:** You did not find anyone who used them?

<sup>4</sup> Ev 21

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**Ms Williams:** Not an international taxonomy. What we found was a number of state-wide taxonomies in Australia or in the United States, very often uni-functional, so only concerned with a particular type of speciality.

**Q64 Mr Bacon:** So is this paragraph wrong?

**Ms Williams:** No, it is not wrong. There are a number of taxonomies around the world which we did review and what we found was there was very little for mental health, in fact none, for learning disability, primary care or ambulance services. There was some work done in some states in some countries that looked at acute services.

**Q65 Mr Bacon:** So you constructed a new classification?

**Ms Williams:** So we worked with clinicians to construct something that was relevant for the UK.

**Q66 Mr Bacon:** Can you tell me whether the next sentence is correct. It says: "... reporting fields, which identify the contributory factors to the incident, are optional, and compliance is variable, even though the learning of lessons is most likely to come from this information." Is that sentence in all its particulars correct?

**Ms Williams:** Yes, it is correct. As I was explaining earlier, not all the commercial risk systems that the trusts have purchased collect contributory factors. We have thousands of reports which do have contributory factors on but this is an area where we want to make changes over the next year or so. We are going to be reviewing our data set, we gave a commitment to review it once we have rolled it out to all the—

**Q67 Mr Bacon:** Do you mean the fields will be obligatory rather than optional?

**Ms Williams:** I think they need to be because that is where the—

**Q68 Mr Bacon:** Is it not rather obvious to make them obligatory if you want to have complete data to work with? You do not need thousands of consultants to tell you that.

**Ms Williams:** The free text in the reports that we currently get reveal an enormous amount and we are able to use that for learning. Certainly ideally we would like the contributory factors but it would mean commercial systems making a change. One of the things that we have been doing is working with Connecting for Health and one of the solutions to this would be a national specification for risk management systems.

**Q69 Mr Bacon:** Is this yet another bell and whistle added on to the original Connecting for Health specification?

**Ms Williams:** I think it is something that we could very closely work with them on. It is a specification that would be tendered but it would give that mandatory flavour which I think we are all asking for.

**Sir Nigel Crisp:** We are holding off the bells and whistles at the moment.

**Q70 Mr Bacon:** May I ask about the Department of Health's identification of the Australian patient safety system which is called AIMS, Advanced Incident Monitoring System? The Department of Health identified that as a workable system but when the responsibility was transferred to the NPSA you did not go with that, as it were, an off-the-shelf working system. You started from scratch. Can you say why?

**Ms Williams:** The Department of Health tendered for a system and when we arrived in post there was a consortium in place between the company that operated the AIM System and a UK-based software system. We decided to let the pilot run. We evaluated it in April 2002 and we found that there were a number of problems. There were technical difficulties and we learned a huge number of lessons but it was not a system that at that time we felt could be rolled out to the whole of the UK.

**Q71 Mr Bacon:** Could I just check that Mr Stuart Emslie, who wrote to this Committee<sup>5</sup> with a note about this system and indeed about what he feels was a waste of money which the Department of Health was engaged in on this procurement, is the same Stuart Emslie who was reported on 2 December 2001 in *The Sunday Times* as having given an internal briefing to the Department of Health the previous month, in November 2001, that 16–20% of your budget disappeared through waste, fraud and mismanagement?

**Sir Nigel Crisp:** I do not know.

**Q72 Chairman:** I understand that this is a matter which is *sub judice*. Under the rules of the House, as our Clerk advises us, it might be difficult to pursue this matter. I understand there is a writ against this man. Is that right?

**Sir Nigel Crisp:** Yes, that is right.

**Q73 Mr Bacon:** I am not wishing, Chairman, to stray into anything that might come before the court. I am simply trying to identify if this is the same person who was referred to in the article in *The Sunday Times* on 2 December 2001.

**Sir Nigel Crisp:** Frankly, I do not have a memory for everything that has appeared in *The Sunday Times* in the last five years, but I would request the Chairman that we do not go into this area, for the reasons that the Chairman has stated.

**Q74 Mr Bacon:** I would just like to know if it is the same person. I think it is right that you can confirm whether it is the same person or not.

**Sir Nigel Crisp:** I suspect it is.

**Q75 Mr Bacon:** Can I ask you one more question, and this may be for Ms Williams again? It is about power generators. In an Adjournment Debate the other day there was an answer by the Minister of

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<sup>5</sup> Not printed.

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State concerning medical injury, the Sarah Lynch brain damage case, a very sad case. One of the problems, and it is arguable to this day, 20 years later, whether this was a contributory factor, was that there was a power cut and the back-up generator also did not work. What data do you keep centrally on the state of back-up generators and whether they are all in good condition and maintained regularly? In this particular incident the back-up generator log book was destroyed. Do you keep data centrally on that?

**Ms Williams:** No, we would not keep data about individual pieces of equipment or estate at the NPSA.

**Q76 Mr Bacon:** It would be at the trust level, would it?

**Ms Williams:** That would be at the trust level. There will have been guidance from NHS Estates in the past requiring trusts to make sure that there were suitable back-up arrangements.

**Q77 Mr Mitchell:** Can I carry on with the National Patient Safety Agency and ask Sir Nigel how he rates the success of the agency in meeting its key target of improving the culture of the NHS? Would you say it was stunning? Would you say it was mediocre? Would you say, in a civil servants' phrase, it was disappointing, or lousy?

**Sir Nigel Crisp:** I would say good and more to do. I think we have come quite a long way but there is an enormous amount further that needs to be done. Why I say good is because we do have this reporting system that is at the level of other people around the world or where we are perhaps leading the way. We do have the 15 safety alerts that I referred to and so on, so I think it is fair to say good but I do think, as this Report reveals, we have got a lot further to go to see improvements, so I am going wider than just the NPSA, but I think they have played a significant part in this.

**Q78 Mr Mitchell:** But come a long way more slowly than everybody would have hoped?

**Sir Nigel Crisp:** I think that is true but I do think that it is a very strong point that they took over a piloting system from the Department of Health, evaluated it, found it wanting and then went on to develop a full Business Case for an in-house developed system, which required Treasury approval. You hope pilots work but if they do not you want proper evaluation. I am pleased that the board and the chief executive had a proper evaluation. That is disappointing but I think we have come a long way.

**Q79 Mr Mitchell:** Can I ask Ms Williams why it took such a long time to get the National Reporting and Learning System off the ground? This was presumably a key task and yet you were messing about for ages.

**Ms Williams:** We could not proceed with the first pilot and therefore we had to ascertain whether it would be possible to roll out a system with just the Australian company that we mentioned earlier. That was also found not to be possible. We also

discovered during that period in 2002 that the scale of the enterprise was such that we needed to seek Treasury approval for a full business case. That was done and from receipt of approval it has taken two years to roll out to 607 organisations, which I think is a major task. Of course we would like to have done it more quickly. However, we did not wait until we had rolled it out before starting work on a range of solutions. We had a number of issues that were raised with us by patients or by members of staff, we worked on those and we issued guidance to try to prevent harm, so we did not wait for the reporting system to get going before we started work on our solutions.

**Q80 Mr Mitchell:** You talk about the Australian system but Mr Emslie tells us that there was an existing NHS Safecode system which was a Crown product developed and funded in this country. Why did you not consider using that?

**Ms Williams:** There are a number of risk software systems developed in this country. I do not believe it would be appropriate to comment further on an individual system.

**Q81 Chairman:** Was it unsuitable?

**Ms Williams:** I do not believe I can comment.

**Sir Nigel Crisp:** The organisation carried out a rigorous evaluation, which is what we would want them to do, speaking for the Department of Health, and having done that evaluation, they carried out an options appraisal which resulted in an in-house system being chosen, following business case rules, in part because they needed to in Treasury terms. They made a judgment based on the evidence available to them at the time.

**Q82 Mr Mitchell:** Did you even consider Safecode?

**Sir Nigel Crisp:** I think this is all part of the issue you talked about earlier, Chairman, and I think we really should not get into this.

**Q83 Mr Mitchell:** So we take it that it was not considered?

**Sir Nigel Crisp:** I am happy at some other point if you want to send you a written note or something but I do not think I am prepared to discuss this particular issue further as this is a matter that is *sub judice*.

**Q84 Chairman:** Would you be more happy giving evidence in private or would you rather not give any evidence at all?

**Sir Nigel Crisp:** I would rather not give any evidence at all.

**Q85 Chairman:** Because it is *sub judice*?

**Sir Nigel Crisp:** Because it is *sub judice*.

**Chairman:** That is our problem. That is the rule of the House. I am quite happy to take advice but under the rules of this House we are not supposed to take evidence on matters which are *sub judice*.

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**Q86 Mr Mitchell:** Why, at the end of the day, when you had devised a system, did you come up with one where the trusts questioned the value of sending data to the system, given the lack of feedback and the lack of emphasis on solutions and given its complications?

**Ms Williams:** In terms of complications we had a choice. We could either create a system whereby trusts reported separately to us, which would have meant reporting once on their own system and separately to a national organisation. We took the view, and it did take longer, that we would integrate our requirements as far as we possibly could into the commercial systems. That has meant at the initial stages a mapping exercise which has caused additional problems for the trusts but once mapped it is very much easier for the trusts to send us information. On the whole question of feedback, we are very aware that unless there is regular feedback this does act as a barrier to reporting. We would argue that we have produced three reports from each of the two pilots that we had, plus the Observatory report last year. As Sir Nigel has said, we have had 15 solutions. We have had conferences, we have run training sessions for 47,000 staff over the period, and therefore in one sense there has been feedback. It is not sufficient and clearly this is something we need to do more of. We have agreed with the Department of Health that there will be quarterly reports coming from the Observatory, which is the term we use where we bring together information from the reporting system together with other information sources—litigation, complaints, *et cetera*. We will publish more regularly on a quarterly basis and we have been piloting an extranet with trusts so that they can get immediate feedback which will enable them to benchmark themselves against other organisations.

**Q87 Mr Mitchell:** But it seems odd, having moved so slowly and looked at this system and rejected that system, for reasons we are not allowed to be told, that you came up with a system which did not satisfy the needs of learning because it does not tell us about the causes of whatever has happened. How can you identify learning when trusts are not required to provide information on contributory factors?

**Ms Williams:** As I have previously answered, we would like to see in future more of this information coming in. Many of the systems do provide this. We have many thousands of reports which do include contributory factors. We do believe that ideally it should be a mandatory field and that is something we would be working on with Connecting for Health.

**Sir Nigel Crisp:** May I make one point on this, which I hope is helpful, which is that the point there is about the feeder systems not requiring that rather than about how they can be collected centrally. That is about using the feeder systems in the trusts.

**Q88 Mr Mitchell:** What we need at the end of the day is guidance on avoiding accidents and that is not what you are able to provide.

**Ms Williams:** We have produced a major guidance document. It is called *Seven steps for patient safety*. It outlines for trusts a comprehensive range of policies which they would need to develop in order to build the infrastructure that would support safety at a local level. On its own it provides the framework within which they develop their systems but on top of that we produce seven or eight other tools and techniques that would support safety at the local level.

**Q89 Mr Mitchell:** Yes, but at the end of the day patient safety incidents cost, it is estimated, a couple of billion in extra bed days, so why have you not done more to develop guidance on costing the patient safety incidents and listing the solutions to them? This seems to be a key weakness.

**Professor Sir Liam Donaldson:** The agency has put out 15 alerts on different subjects. Over the same period of time the Joint Commission in the States, which is probably the international benchmark for putting out these sorts of solutions to reduce risks, put out ten, so they have put out very extensive guidance and several of them are in areas where the cost savings are very big. Sir Nigel mentioned the cleanyourhands campaign. There is the whole question of the infusion pumps which cost lives and cause harm, so there are some very significant steps that have been taken in my view, and once the analysis of these nearly a million reports is more fully developed I think the solutions will flow out even more swiftly. They have looked, for example, at misplacement of nasogastric tubes which cost the lives of children and babies. They have looked at wrong site surgery. All of these things are very important measures to reduce risk in specific areas as well as the general *Seven steps* type of approach which Ms Williams has mentioned.

**Q90 Mr Mitchell:** Yes, but this is an agency which is our agency which is supposed to develop solutions to our problems in a field where you told us at the start of this that we were world leaders and doing very well, thank you very much, an agency which has already rejected Australian experience. Why should we be reliant on the Americans in this kind of field? Why is it not doing it itself?

**Professor Sir Liam Donaldson:** If you look around the world we are one of the few countries to have a nationwide system. The Americans have only got systems in certain parts of the country, so have the Australians. Indeed, the number of incident reports we have already I do not think has been surpassed anywhere in the world. Proportionate to the size of the populations, we are level with the Veterans Administration which covers 7 million people in the States. We cover 53 million people, so both numerically and proportionately I think we are in the lead. Other countries, and indeed other industries, have shown that you have to get high quality data in before you can start analysing. As Ms Williams has said, even before the data are fully in they have put out 15 alerts, which I think is quite a strong record, certainly in comparison to the other example that I gave.

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**Q91 Kitty Ussher:** As somebody who is not expert in this particular field of policy, reading the brief and the NAO's Report for the first time, I must admit I was immediately rather scared. I think the number of one in 10 is much higher than members of the public would expect and is certainly way higher than they would hope for. The idea that when you go into hospital and your life and welfare is in someone else's hands and in one in 10 times it will be made worse in accidents rather than something internal is really quite terrifying. I have heard you say that you think things are improving but obviously there is a long way to go. Could you describe the situation before Ms Williams' agency was established so that we have some kind of benchmark about where it started from? Where were we 10 years ago, for example?

**Professor Sir Liam Donaldson:** Perhaps I could start on that. Ten or 15 years ago many members of the medical profession would say there was no such thing as a bad doctor. Many would say that you could not measure quality so why bother to try and improve it. Over the last five or six years we have put in place a comprehensive quality framework in this country which is admired internationally, with clear national standards, with inspectorates. Safety is the first of those national standards that were issued a year ago on which the Healthcare Commission inspects. At local level every hospital has now a duty of quality, and again that is very unusual compared to other countries, and local programmes of what we call clinical governance (which is a way of ensuring that clinicians are involved in quality assurance), quality improvement and safety are in place, and indeed the NAO Report talks in positive terms about our clinical governance programme, so things have moved on a lot. This strand of safety has been added to that overall programme and I think has in place the ingredients necessary to improve safety very considerably: the cultural change, the technical support with reporting and learning systems, the area which we are working on at the moment to improve education and training. If you take the particular element about poor practice and bad doctors, as I was saying earlier, we have also moved forward very substantially on that in identifying bad doctors early, trying to rehabilitate where possible but ensuring that patients are protected at an early stage. There is more to do but the emphasis is very much on quality and safety in the NHS today.

**Q92 Kitty Ussher:** What was the trigger for the establishment of the agency?

**Professor Sir Liam Donaldson:** It was a report that I produced called *An Organisation with a Memory*. I had had a longstanding interest in and had read a lot about the work that was being done in the airline industry and the way that they had managed to improve safety over many years and I thought that there would be a comparable programme that could be launched in healthcare.

**Q93 Kitty Ussher:** Was there any national budget stream for patient safety in the holistic rational sense prior to the establishment of the agency?

**Professor Sir Liam Donaldson:** Not specifically, no, and one was created by the implementation of *An Organisation with a Memory*.

**Q94 Kitty Ussher:** In your opening remarks in your conversation with the Chairman you suggested that you should write to the Committee with the international comparisons to make sure that we had up-to-date information. Since then you have mentioned a couple of other instances. Since members, if you will permit me, Chairman, keep saying, "How does our one in 10 stack up when compared internationally?", and you have mentioned that we are a world leader now, could you expand on that answer a little bit more and give us a quick indication of where we now stand compared to other countries?

**Professor Sir Liam Donaldson:** In developed countries the ball park figure of one in 10 hospital admissions resulting in some form of error or mistake is probably comparable across all countries. We do not know what the position is in developing countries. One would assume that, because of their poor infrastructure and resources, the problems there would be more serious, but the World Health Organisation is currently researching that. As far as the scale of the problem is concerned we are probably broadly comparable with other developed countries and certainly there is a great deal of concern in the US about the level of inadvertent harm caused by their healthcare system. As far as making commitment to action is concerned, we are in the forefront, although commitment and enthusiasm are growing across many countries in the world now and I have talked to people in other countries about what they are doing. The area where we need to achieve more is in this area of implementing risk reduction measures because, aside from some limited evaluations of the benefits of introducing, for example, electronic medicine prescribing into some parts of the world, there are very few examples of where reductions in risk can be quantified and attributed to particular interventions. We are trying to learn as much as we can from the researchers and from what is happening elsewhere as well as implementing our own programmes.

**Q95 Kitty Ussher:** Given that we had not done much until very recently and given, as you seem to imply, that many other countries are in the same situation, if we are all on a ratio of one to 10 what do you think potentially, hypothetically, that ratio can be reduced to once we all operate at the maximum of our potential? I am not talking about the timescale but if that could become in theory one in 15 or one in 20 do you have a sense of the potential improvement there?

**Professor Sir Liam Donaldson:** Given the experience of other industries, those scales of reduction are achievable and I do not think there is any reason why healthcare could not achieve the same sort of record of year on year improvement.

**Q96 Kitty Ussher:** One in 20 then would you consider?

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**Professor Sir Liam Donaldson:** It is difficult to put an exact figure on it.

**Q97 Kitty Ussher:** But that order of magnitude?

**Professor Sir Liam Donaldson:** Yes.

**Q98 Kitty Ussher:** You mentioned the implementation mechanism for the things that you have found out, which was going to be my next question, and I presume Ms Williams is the most appropriate person to answer. You have described how incidents are reported and you obviously now have a large quantity of data. You have said that you have issued 15 alerts and have this training agenda and the cleanyourhands campaign. I launched our own cleanyourhands campaign in my constituency so I know it is there, but what kind of enforcement powers do you have and what kind of checking or accountability powers do you have to make sure changes are made?

**Ms Williams:** The NPSA itself does not have enforcement powers. There are three ways in which it is possible, if you like, to find out whether anyone is taking any notice of what we are putting out. The first thing is that we do have our own evaluation programme where we look to see what are the barriers to implementing our suggestions because we ourselves want to learn for future products how we can make it easy for people to implement our solutions. Secondly, and very importantly, the alerts go out through an alert system which is monitored by strategic health authorities. It is called the SABS system, so when something goes out trusts are required to indicate whether they are taking action, whether it is appropriate to take action, and when they will take action, so there is that performance monitoring. The third important strand is that the Healthcare Commission, which, as well as self-assessment, will be undertaking random inspections, have agreed to include in their criteria a check on a random sample of alerts that we put out, so they will be absolutely able to see a demonstration that something has happened at the other end.

**Q99 Kitty Ussher:** That is reassuring. Has any of that actually happened yet? Do you have any data as to how effective you are being?

**Ms Williams:** We have some examples. One of the topics we took was the standardisation of the crash call number. Standardisation is a common safety solution. What we found before we standardised to four twos—this is where you call for help from a team if somebody is having a cardiac arrest—was that there were 27 different telephone numbers across the Health Service, so staff clearly moved from one to another site and very often agency staff would be working across different locations. As at the end of 2005 all trusts have standardised to the four twos, 2222, so this is the standard number that can be used right across. Another example would be one of our very early alerts. Potassium chloride has already been mentioned. We asked trusts to withdraw it from general ward areas. This is a very toxic drug in its undiluted form. Before we put out our alert we did a base line. 32% of ward areas had

not got this drug on their shelves, as it were. We checked two years later and in fact we are up to 98% of wards that have now removed it from their ward areas. This reduces the likelihood of a member of staff in a hurry reaching for this drug and giving it in an undiluted form.

**Q100 Greg Clark:** Ms Williams, what is the annual budget of your organisation?

**Ms Williams:** The original NPSA budget was £15 million a year.

**Q101 Greg Clark:** The original one?

**Ms Williams:** From 1 April 2005 we took on a range of additional responsibilities following the Government review of arm's length bodies and that added an extra £20 million or so to our budget.

**Q102 Greg Clark:** So the budget for next year is what?

**Ms Williams:** It is of the order of £44 million.<sup>6</sup>

**Q103 Greg Clark:** How many employees do you have working for you?

**Ms Williams:** With our new responsibilities we have 316 whole time employees.

**Q104 Greg Clark:** How long have you been Chief Executive of the organisation?

**Ms Williams:** Since its inception in October 2001.

**Q105 Greg Clark:** During that time have you identified any principles that would tend to make the hospital more safe and less prone to these patient safety incidents?

**Ms Williams:** What we have identified, having looked at other industries, is aspects of what we would call a safety management system. There are certain things that need to be in place that would tend to lead towards a safer environment.

**Q106 Greg Clark:** Can you give me some examples?

**Ms Williams:** They are a reporting system, an open and fair culture (which can be tested), a root cause analysis of serious incidents when they occur, feedback to staff, multidisciplinary teamwork, communications, work on those particular areas, handovers, and then time for learning. We found in some trusts that they had very well developed systems where on a regular basis the multidisciplinary team sit down—and it can happen in a GP practice or in a specialty—and discuss, “What has gone well, what has not gone so well, what can we put in place to prevent risk occurring?”. It is that sort of drive that we want to see extended right across.

**Q107 Greg Clark:** That seems very sensible and I would expect that, but it strikes me, just reading the Report, that some of those principles do not seem to apply to the organisation itself. Take learning, for example. Mr Bacon has already raised a point about international comparisons and I detect a note of

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<sup>6</sup> *Correction by witness:* The NPSA budget for 2005–06 is £35.154 million. Also see Ev 19–21

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criticism in the NAO Report when it says, “. . . and, despite the existence of well developed international incident classification, the National Patient Safety Organisation decided to define its own taxonomy and national reporting and produce tailored versions for use in nine different healthcare settings”. For an organisation that is there to promote learning it seems strange that you would ignore the international examples and go for something that is entirely unique.

**Ms Williams:** We did not ignore them. We went through a process of reviewing the classifications that we could find internationally and, as I have previously said, we could not find any taxonomies that related to mental health, learning disability, the ambulance services, primary care. There was some work done on acute services in some parts of the world.

**Q108 Greg Clark:** But just on acute services is it not possible to take in that, which is, I would imagine, a large portion of the incidents?

**Ms Williams:** Again, when you look at any other national system, there is always a need to customise it for the local language—

**Q109 Greg Clark:** Customise, yes, but to start from scratch seems extreme.

**Ms Williams:** We felt that we needed a system that had local clinician support and we went through a process which involved several hundred clinical staff to reach a taxonomy that learnt from others but actually met the requirements—

**Q110 Greg Clark:** It strikes me that as an organisation you advocate learning but do not seem to have done much learning yourself when it comes to this.

**Sir Nigel Crisp:** Can I just say something there? I think that paragraph does say that there are well developed international incident classifications, but the point that Ms Williams and colleagues are making is that they are not comprehensive and we wanted a comprehensive system that covered all patients. Whilst it is appropriate to learn from other people, we now actually have a system that does cover the whole patient population.

**Q111 Greg Clark:** I would have thought in the context of this organisation that learning implied sharing best practice rather than adopting a unique approach. Let me move on to another principle. It strikes me that it would be reasonable to suppose in any discussion of safety that mistakes happen when procedures are complex and unclear. I assume that would be a common sense assessment. Would that be reasonable, that complexity is an area of safety?

**Ms Williams:** Yes, complexity is plainly going to create a more difficult environment.

**Q112 Greg Clark:** But then we see on page 34 of the Report, paragraph 2.30, that the NAO concludes that trusts “face an extremely complex system of reporting and investigation”. For an organisation

that is, one would hope, aiming to promote simplicity and clarity that is a dreadful conclusion from the National Audit Office surely.

**Ms Williams:** It is true to say, as the Report makes clear, that there are a number of bodies to which trusts should report and some of these are for very good statutory reasons, whether it is for overdose of radiation or whether it is the Health and Safety Executive, or whether it is the Health Protection Agency which offers surveillance for—

**Q113 Greg Clark:** Surely, for an organisation to be about simplicity and clarity, to have a conclusion from the National Audit Office that described not just a complex system but an extremely complex system of reporting and investigation, that seems to be dysfunctional.

**Sir Nigel Crisp:** To be fair, if I may come in, if I am reading paragraph 2.30 properly, I do not think that is purely about the NPSA. I think that is about the fact that trusts do have to report to a lot of people.

**Q114 Greg Clark:** Shall we read it out: “. . . the National Reporting and Learning System added to the list of organisations to which trusts were already required to report and trusts still face an extremely complex system of reporting and investigation. Figure 14 overleaf”, it goes on to say, “shows the main national reporting systems, but around 30 routes still remain.” That seems extraordinary.

**Sir Nigel Crisp:** The point I was making was that I am not sure that is entirely fair to lay that at the door of the NPSA because if you look at those if you look at those other agencies, police and coroners and other people, they require information as well, and it is not surprising that they do. What we have discussed is—

**Q115 Greg Clark:** The problem is, is it not, that the way the NPSA has gone about its work has duplicated the systems in place rather than added to them? For example, if we take Appendix 5, page 71, the final bullet point says that “trusts that were visited felt that the local systems were more important for learning lessons”. As far as I understand it, one of the objectives of this organisation, the National Patient Safety Agency, is to promote learning and yet we find that their own systems are not, practitioners find, the best place to promote learning; it is the local systems that have been added to. That again is not a happy conclusion, Ms Williams.

**Sir Nigel Crisp:** I think there are two points here.

**Q116 Greg Clark:** Ms Williams’ perspective is the one we would like to have.

**Ms Williams:** Of course, local learning is absolutely vital and it is the building block on which any national system will sit. However, what a local system cannot do necessarily is pick up themes and trends that are applying across systems. They will only know of the incidents that they report locally. They will not know that actually it is part of a trend that is quite widespread. Only a national system can do that.

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**Q117 Greg Clark:** Just on that point, Ms Williams, paragraph 2.37 says that the National Patient Safety Agency “could have collected aggregate information on commonly occurring incidents that trusts knew about and used it to promulgate learning nationally”.

**Ms Williams:** We did look as part of our business case at a range of options and one of them was aggregate collection of data. This would not have allowed us to pick up the individual reports on a particular issue. It would have provided summaries of information, statistical information. It would not have yielded the richness of the reports that we have received and that we are able to take action on. On our very first alert, if I could give you that example, we had 40 individual reports on a particular drug which meant that we were able to take action. If it was aggregated information all we would be able to receive would be something like 2,000 medication incidents. That is not a basis on which we could have taken action.

**Q118 Greg Clark:** Your organisation had an objective to be a leader in this field, to promote the profile of patient safety. You were established in 2001. In 2005 77% of junior doctors said that they needed more information on what your agency was about and 60% have never heard of you. Is that a good performance?

**Ms Williams:** We know that doctors internationally, not just in this country, are a particularly hard group to reach in relation to patient safety and reporting. That is precisely why we mounted a campaign this year to increase the knowledge. We have, through doctors.net.uk, which is a web-based organisation that many thousands of junior doctors in training are members of, found that now 10,500 doctors in training have been through that programme.

**Q119 Greg Clark:** I was interested in the results of that. I agree this seems a commendable thing but, having gone through this programme of creating awareness, initially 13% thought the organisation would improve patient safety. As a result of people going through the process it rose to 34%. In other words, having been made aware, having been briefed and having gone through a course, 66% of doctors still thought that this was not going to make a difference.

**Professor Sir Liam Donaldson:** If I could just add on that, we have put into the training programme for all junior doctors from now on a competency on patient safety, so I think that situation will dramatically improve over the next few years.

**Q120 Chairman:** Why?

**Professor Sir Liam Donaldson:** Because they will not be able to ignore it. They are going to be tested in examinations which determine their career progress.

**Q121 Chairman:** As I understand these questions that Mr Clark was putting to you, there is too little feedback. People just do not feel that the work of this agency is making a great deal of difference. That is as I understand his 10 minutes of questioning.

**Professor Sir Liam Donaldson:** Ms Williams has mentioned the feedback that they have done. I have regularly, in my Chief Medical Officer’s newsletter to all doctors, mentioned patient safety, I have mentioned the role of the agency, I have emphasised the importance of reporting. As I say, it is a world first to have in the training curriculum a competency for all doctors on patient safety. We have a lot more still to do but we are taking some quite strong steps.

**Q122 Mr Williams:** Sir Nigel, you found succour in table 23, page 67, on the international comparisons?

**Sir Nigel Crisp:** I do not know if I found succour in it.

**Q123 Mr Williams:** You were quoting it as showing not unreasonable results as far as the country was concerned.

**Sir Nigel Crisp:** These were results over a number of years and I think what I said was that I was not quite sure what this showed, and then we went on to Sir Liam talking about international comparisons that he was aware of. I was not particularly taking succour from that. It seems to me that that shows really quite a mixed picture.

**Q124 Mr Williams:** It is meaningless, is it not, as a table? It has only got two London hospitals representing the whole of the UK and there, when it comes to preventable adverse events, we are second worst out of the whole list in the table.

**Sir Nigel Crisp:** I am not sure that table offers us much insight.

**Q125 Mr Williams:** That is all right, as long as you are not shouting behind. I probably misunderstood.

**Sir Nigel Crisp:** That is what I was intending to say.

**Q126 Mr Williams:** I just wanted to make sure no-one laid any confidence on that because it is statistical gobbledygook. It is utterly meaningless. The reality is better reflected, is it not, on page 25, and very worryingly reflected, where you deal with the number of incidents?

**Sir Nigel Crisp:** Yes.

**Q127 Mr Williams:** And in table 6. I know you must be as worried about this as I would be, but it seems to me when you get a range from almost nil at one end to 13,000 at the other end between trusts, that someone is not telling the truth, are they?

**Sir Nigel Crisp:** I think the table on page 6 actually reflects reporting practice rather than number of incidents, and that is partly because of the timetable.

**Q128 Mr Williams:** Exactly, that is what I mean, someone is not telling the truth because they are not reporting, they are not recording.

**Sir Nigel Crisp:** I have to say some of these trusts only came on to the reporting system during the course of the year in question I think.

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**Q129 Mr Williams:** If you look at the table, the median figure, because you cannot get an average, comes out at 3,700. The worst is three times worse than that at 13,000 in that year.

**Sir Nigel Crisp:** Yes.

**Q130 Mr Williams:** Then, at the other extreme, you find people having recorded nothing at all. Either they are unbelievably competent or they are just concealing the truth, or not interested in finding the truth.<sup>7</sup>

**Sir Nigel Crisp:** Or possibly they are not connected to the system or they became connected to the system during part of the year.

**Q131 Mr Williams:** It is the median, so you cannot really say that.

**Sir Nigel Crisp:** I beg your pardon. Yes.

**Q132 Mr Williams:** You referred to a figure of 50,000 per month and I missed what you were talking about there.

**Sir Nigel Crisp:** What we are getting at the moment is 60,000 incidents being reported to the NPSA a month.<sup>8</sup> In this document it was about 40,000, which was the figure quoted in this Report, which shows how fast it is increasing.

**Q133 Mr Williams:** So that is 720,000 a year?

**Sir Nigel Crisp:** Something of that sort, yes.

**Q134 Mr Williams:** We are told by the NAO and it is reflected in this table that only 24% of the trusts bother to routinely tell patients when they have been involved in an incident. It could happen under an anaesthetic, it could mean you were given drugs which you should not have been given. How on earth can they justify 1:4? Or, put the other way, how can they justify 3:4 not telling the patient?

**Sir Nigel Crisp:** I agree, I would not want to justify it.

**Q135 Mr Williams:** So what are you going to do about those? It does have consequences, does it not? If you have not been informed it could well be that it has had a medical effect which is serious to you and you do not even know the hospital was responsible, but also if it is not reported then the GP does not know about it, so in any subsequent diagnosis, looking at this patient, he is unaware something

happened in the hospital which could have been the cause or contributed to the new situation. That is very, very worrying indeed, is it not?

**Sir Nigel Crisp:** Indeed, I think it is, and that is precisely why we are paying so much attention to this, because these incidents have not just happened because we are starting to report them. It is actually important we are starting to report them so we do something about them and pick them up in the ways you are talking about.

**Q136 Mr Williams:** If we look at the number of incidents—I assume these are the incidents recorded in that table on page 25—the top number reported is 13,000.

**Sir Nigel Crisp:** Yes.

**Q137 Mr Williams:** Are we to believe that three-quarters of those, say 9,000, were not actually reported to the patients? Is that not what follows from the 24% figure?

**Ms Williams:** We know that because of a range of reasons—fear of retribution, the general atmosphere in which reporting takes place—there are some places where staff are more nervous of speaking up than others and to tell patients, but we have issued a policy in September—

**Q138 Mr Williams:** But there are an awful lot of patients out there who have been denied the information they should have had, and in some cases needed to have, and this could have an effect on their future health and also on their rights, because if it had been a preventable incident then they do have a right to take action. It is not antisocial to take action if you have suffered a serious health injury as a result of something someone else could have prevented. What are you doing about all these people who are wandering around unaware they have been the victims of failures by medics? If you have a constituent who complains against a consultant and you take it up with the trust, you are likely to find that the consultant might no longer want to see the individual who dares to complain. It is stacked, is it not, against the patient?

**Sir Nigel Crisp:** I think there are a number of points here. We are now starting to get this information so we know what is going on. You can see in various places in this report, including the stuff for example on the North East Strategic Health Authority, how they are trying to change the whole system in the North East to make sure actually it is the norm that people report, that you do have a no blame culture and you do get into the position which you are precisely describing of where we want to be. We have also got, as Sir Liam has said, the new NHS Redress Scheme which will make it easier for people to deal with the more minor incidents without getting tied up into legal issues.

**Q139 Mr Williams:** If they are ever told about them.

**Sir Nigel Crisp:** I agree with the point you are making. Even though two thirds of these are things which do not actually harm the patient, they should nevertheless in principle know what has happened.

<sup>7</sup> Note by the National Audit Office: Mr Williams referred to the data the National Audit Office collected (presented in figure 6 of the C&AG's Report) which were supplied by NHS trusts directly from their own Incident Recording and Risk Management systems. The NAO quantification of the number of reported patient safety incidents in England for 2003–04 and 2004–05 was not dependent on the trusts being linked to the National Patient Safety Agency's National Reporting and Learning System. Therefore, an NHS trust that reported only four recorded patient safety incidents would have made a similar return to the NPSA if it had been linked to the National Reporting and Learning System.

<sup>8</sup> Note by the National Audit Office: As the Permanent Secretary is referring to the NAO Report it should be noted that the figure quoted is in fact 85,342 incidents reported to the NPSA between December 2004 and March 2005, ie over a period of 4 months (at best 22,000 per month).

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**Ms Williams:** We launched a policy called *Being Open* in September, and this year we are running training programmes for trusts using a variety of techniques for staff to be aware of the policy where we are saying very clearly as an agency that you should tell the patient or their relatives, you should offer an apology and you should involve them in the investigation and discuss with them what action should be taken to prevent harm to others. That training programme involves trusts developing their own policy as to who should tell the patient, in what circumstances, and actually what we have found is that staff themselves need training and practice in telling patients. It is a very traumatic thing for example to tell a family that maybe an overdose of medication has been given, and what we have discovered in our work is that clinical staff themselves need support from their organisation and training in how to do that and how to do it well.

**Q140 Mr Williams:** I am glad that you are trying to address the problem you have identified. Why, though, were you two years late in setting up your system to collect all incidents? What had been the target time for you setting it up?

**Ms Williams:** The target in *Building a safer NHS* was to have the system up and running and connected by December 2002.

**Q141 Mr Williams:** How many months was that?

**Ms Williams:** From when we arrived in post that would have given us about a year.

**Q142 Mr Williams:** And you were two years late on that, so that was three years?

**Ms Williams:** We delivered the system in two years from the date of the Treasury approval.

**Q143 Mr Williams:** The Report says to us it was set up two years late. Is that correct or incorrect?

**Ms Williams:** As we discussed, we did have a pilot scheme which was evaluated and we found it was not something we could roll out. The Health Service has often been criticised for rolling out pilots and we were very careful to make sure that when we evaluated it we looked very closely to see whether it was a system which would work in all 607 trusts.

**Q144 Mr Williams:** Did the Department set the target?

**Sir Nigel Crisp:** We would have set the original target.

**Q145 Mr Williams:** You got it wrong, did you not?

**Sir Nigel Crisp:** We did?

**Q146 Mr Williams:** Either you did or they did. I do not mind which one puts their hand up.

**Sir Nigel Crisp:** We set a target which was by a certain date this should be delivered. We then set up the NPSA to do it. In the event what happened was we had started a pilot process before we set it up with the NPSA, the pilot was not successful and the NPSA evaluated it—and I think I have been criticised by this Committee before for not

evaluating things properly—people here did evaluate it and as a result they bit the bullet that they needed to have another scheme that would work better and that is what they have done. That is why it is two years late.

**Q147 Mr Williams:** This probably looks good in a Parliamentary Answer to say it is up and running in one year but then you sit back and hope everyone will forget how you got to that.

**Sir Nigel Crisp:** That is not how we handle targets. We have a good record on targets and this particular target was not met by the health system, and we are part of the health system. I am content to be very clear with you on that, just as on other occasions I have been very clear when we have hit targets.

**Chairman:** We still have a few supplementary questions.

**Q148 Mr Bacon:** Ms Williams, you said your budget is now £44 million, can you say how much of that is spent on employing staff, on staff salaries?

**Ms Williams:** Staff at the headquarters, I would say is about £30 million or so.

**Q149 Mr Bacon:** Do you have people deployed regionally as well?

**Ms Williams:** Yes, we do.

**Q150 Mr Bacon:** I was talking about the total. Of your £44 million and your 300 or so staff, how much goes on salaries?

**Ms Williams:** I would say it must be £40 million or so.

**Q151 Mr Bacon:** The majority of it?

**Ms Williams:** Yes.

**Q152 Mr Bacon:** I did a little sum and £40 million divided by 300 people gives an average salary of £133,000, or an average cost of employing somebody including everything else of £133,000. Is it possible you could write to the Committee with a more detailed breakdown of your budget and, in particular as far as salaries are concerned, stratify them as would happen in a company annual report within each strata of £10,000, so we know the number of people above £30,000 and so on all the way up? Is that possible?<sup>9</sup>

**Ms Williams:** Yes. I have just been corrected, the staff total is £34 million.

**Q153 Mr Bacon:** If you could write to the Committee on that, I would be most grateful. The other thing is I noticed in your biography it appears you have had five posts as joint chief executive with Sue Osborn. Is that right?

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*Ms Williams:* That is right.

**Q154 Mr Bacon:** Since 1990?

*Ms Williams:* That is right. She is sitting behind me.

**Q155 Mr Bacon:** Why have you had all these posts jointly together? Do you work-share?

*Ms Williams:* It is a job share.

**Q156 Mr Bacon:** So you have consistently throughout your career moved with the other Sue because you job-shared a series of jobs?

*Ms Williams:* Yes.

**Mr Bacon:** Okay.

**Chairman:** You do not want to job-share with me then, Mr Bacon!

**Q157 Jon Trickett:** Here is a case which I heard of lately. A young woman giving birth was in labour for 32 hours, and for the last 24 hours she was asking for a caesarean which the clinicians told her was not necessary. Eventually the heart beat weakened but still the caesarean did not take place until they discovered that inadequate oxygen was getting to the infant's brain and then an emergency caesarean took place. It is possible to hypothesise three possibilities. One is that the guidance to those clinicians was, "Don't do a caesarean unless it is an emergency". Second, that the appropriate level of decision-maker was not present for the last part of the labour, in which case it is probably not negligence but it is still an accident. The third one is that somebody was negligent. I wonder about this no blame culture, frankly, because the child is now having brain scans to see what damage has been done by the failure of the hospital to do what was right by the mother and child. Supposing it was negligence, how does this no blame culture work? Let me say that the mother is not a very educated person and she just thinks it was an incident which happened because nobody has gone to her and said, "We have made a mistake here, we should have done something else", and no one is tying the child's passive character to the fact this happened during the birth process.

**Professor Sir Liam Donaldson:** On the specifics of the case, I do not know the detail but we would be happy to investigate if you sent them to us. Speaking generally, having a no blame culture does not mean that nobody can ever be held to an account as an individual. If their conduct has been negligent, careless, incompetent, then clearly there are circumstances in which an individual could be held to account. The problem in the past has been that understanding safety has been posed too much around the individual's role in it and has not acknowledged all these wider system things. Speaking again in general terms about the kind of example you give, you are quite right to say that it

could be factors to do with the organisation of services, and so there is a need to acknowledge that individual accountability is not removed from a general no blame culture; it is a question of balance.

**Q158 Jon Trickett:** So how would the management become aware of this?

**Professor Sir Liam Donaldson:** Such an incident would be reported as an adverse outcome of care.

**Q159 Jon Trickett:** But nobody has said this is an adverse outcome of care.

**Professor Sir Liam Donaldson:** I do not know the detail of the individual case but—

**Q160 Jon Trickett:** I was hypothesising three possibilities on the facts of the case. This has happened and it does happen from time to time, but how would the incident be reported? At what point would blame be attributed, if blame was to be attributed? It seems to me it has not been regarded as an incident really.

**Professor Sir Liam Donaldson:** Such an incident—again not talking about the specifics of this one—should be identified locally, reported locally and it should then be investigated and the causation of it analysed and conclusions drawn and changes implemented to prevent such an incident in the future.

**Q161 Greg Clark:** A question to Sir John. The National Patient Safety Agency now costs £44 million and some of us have been a bit concerned about some of the practices we have heard about. Have you been able to come to a view through this study whether as an organisation it offers value for money?

**Sir John Bourn:** I think the view we have come to so far is that you can certainly identify some trusts where there is what I might call a fearless yet sensitive analysis of accidents and improvements have been made, so you can find individual cases of value for money. It is also true that in terms of the Agency we have not yet reached a point where you can say value for money is being secured by it because we do not yet have a national system of analysis and sharing lessons which is fully used, so we have not yet got to the point where we are getting full value for money from the money that is going on the system.

**Greg Clark:** Thank you very much.

**Chairman:** I think that is an appropriate place to end. I am afraid I have to say to you, Ms Williams and Ms Osborn, that it is very likely when we produce our Report we will be issuing a question mark about whether your organisation does provide value for money, given it was set up in 2001 and the delays there have been in bringing in the system. Thank you very much.

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**Supplementary memorandum submitted by the Department of Health**

*Question 2 (Mr Edward Leigh): Updating information relating to patient deaths*

There remains considerable discussion, both nationally and internationally, over the variation in estimates of death due to patient safety incidents. This was reflected within the National Audit Office Report *A Safer Place for Patients: Learning to improve patient safety*. The NAO noted 2,181 deaths in response to their survey—we do not know whether this figure was adjusted for the over-reporting of deaths which would not be strictly classified as patient safety incidents. Staff may report deaths of people who died as a result of their illness rather than an error, although an error may have occurred in the course of their care.

In July 2005, the NPSA published its first Patient Safety Observatory (PSO) report where we gave an estimate of 840 deaths that would be reported to us from acute trusts only. The estimate was based on data from consistently reporting trusts and was also adjusted for over-reporting of deaths which were not patient safety incidents.

Further caveats apply to an estimate of deaths reported to the NRLS, in addition to those for the number of incidents:

1. attributing a patients' death to an incident is not straightforward;
2. trusts may record deaths as incidents, even when no patient safety incident has occurred, in order to support other risk management or local requirements (for example deaths of mental health service users outside of hospital are often reported within mental health trust risk management systems).

In order to try and reconcile the difference between NAO and NPSA figures, we have tried to estimate deaths in mental health trusts (it was felt that reported deaths in ambulance trusts were likely to not make a large enough difference to the numbers, the exercise was more about reconciling figures than about arriving at a very precise figure).

Work done has given a very approximate estimate of deaths from mental health trusts of 1,350 deaths/year. This estimate has been made on the basis of:

- reporting rates from consistently reporting trusts (1.55/100 bed days);
- numbers of bed days in England in 2003–04 (6.7 million, from Hospital Episode Statistics);
- proportion of reports from mental health trusts which are deaths (1.3%);
- this estimate does NOT adjust for over-reporting of deaths which are not PSIS This proportion is likely to be higher than for acute trusts, on the basis of analysis for the forthcoming PSO report.

It is not feasible to estimate deaths from other settings, given the relatively low reporting rates from ambulance trusts at the moment.

Despite the limitations of this analysis, we conclude that much of the difference between the NPSA and NAO estimates is likely to be because the NAO estimate includes mental health trusts, but the estimate in the PSO report was for acute trusts only.

840 (July PSO report) + 1,350 (estimate from mental health trusts) = 2,190 deaths (compared to NAO figure of 2,181).

*Question 6 (Mr Edward Leigh): Update of international comparisons made in the NAO Report*

In the increasing number of countries where research has been carried out, studies consistently show similar levels of health care errors, broadly in the order of 10% of hospitalisations.

The NAO Report [Appendix 4, third paragraph and figure 23] makes the point that a comparison of international studies found an average incidence of 8.9%, and also that “the variation in data can in part be explained by differences in the underlying methodologies for screening records to determine patient safety incidents”.

Health care systems the world over are turning their attention to the importance of focusing on organisational culture and underlying systems for improving patient safety. International research suggests that healthcare is no more unsafe in the UK than in the USA, Australia, New Zealand or Denmark. No country can yet claim to have completely solved this problem.

More generally, through our drive for safer patient care, this country is acknowledged as one of the world leaders in patient safety: in recognising the problem and systematically trying to address it.

The World Health Organisation has recognised the innovative work being done in this country, in developing the World Alliance for Patient Safety—launched 27 October 2004 in Washington. The World Alliance for Patient Safety has identified a number of key actions required to enhance patient safety in any country:

- increased ability to learn from mistakes through better reporting systems
- greater capacity to anticipate mistakes and probe systemic weaknesses

- identification of existing knowledge resources
- improvements in the health-care delivery system itself, so that structures are reconfigured, incentives are realigned and quality placed at the core of the system.

Against these requirements, as the NAO Report acknowledges [Appendix 4 figure 24], we compare very favourably with other countries. As examples, we have established:

- a truly national approach to patient safety with one of the few national reporting systems [note: American and Australian systems cover only parts of each country]
- a national body to focus our efforts to improve the safety of patients
- “safety” as the first domain of the new NHS Standards—against which the Healthcare Commission assess NHS Trusts
- numbers of incident reports to our national system that are unlikely to have been surpassed anywhere in the world, either numerically or proportionately.

As noted in the NAO Report [eg paragraph 2.5], higher levels of reported incidents suggest a safer culture within health care organisations.

Reporting levels to the NPSA’s national system continue to increase significantly, suggesting improvements in safety culture across the NHS. Staff from all NHS Trusts are now reporting patient safety incidents to the National Reporting and Learning System (NRLS)—with the NPSA currently [at January 2006] receiving around 60,000 reports every month.

Reporting levels to the NRLS in England and Wales are already broadly level with those to the Veteran’s Administration (VA) system in the USA, established in 1999, and significantly higher than those to the Danish national system, established in 2003.

In terms of whether reporting to a national system should be anonymous or confidential:

The NAO review itself makes the case for anonymous reporting in paragraph 2.16, which suggests an anonymous reporting system to tackle the acknowledged problem of under-reporting in medication errors and drug-related incidents.

There are advantages in having anonymous or confidential reporting. In this country, our aim has been to raise the level of reporting rates. A system where reporting is anonymous at the national level was felt to be the best means to achieve this in the short term.

Our approach is similar to that taken in the Danish system, where reporting is also confidential at the local level—allowing local action and follow-up—but anonymous on the national reporting system.

In terms of whether reporting to a national system should be “mandatory”:

In this country, reporting errors forms part of the assessment criteria for the NHS Standards, independently assessed by the Healthcare Commission, reporting is now, in effect, “mandatory”.

At the same time, the NPSA’s position has been to encourage (rather than enforce) a culture of reporting—with the emphasis on ensuring that the reporting system is seen to be non-punitive.

For international comparison, the Danish system places an obligation on frontline personnel and Hospital Owners to report incidents, whereas the Veteran’s Administration (VA) system in the USA has, as guiding principles, voluntary participation, confidentiality protection, and non punitive reporting.

*Question 102 (Mr Greg Clark) & Question 152 (Mr Richard Bacon): Detailed breakdown of NPSA budget*

The NPSA budget for 2005–06 is £35.154 million.

Following the publication of *Reconfiguring the Department of Health’s Arm’s Length Bodies* in July 2004, from 1 April 2005 the NPSA assumed responsibility for:

- the National Clinical Assessment Service (NCAS, formerly the National Clinical Assessment Authority);
- the Central Office for Research Ethics Committees (COREC);
- the Better Hospital Food Programme, some aspects of cleanliness in the NHS, the safety of hospital design (transferred from NHS Estates);
- and the contracts with the confidential enquiries into maternal and child health (CEMACH), patient outcome and death (NCEPOD) and suicide and homicide by people with mental illness (NCISH)—which moved from the National Institute for Clinical Excellence and Health.

**This merger released £1,360,000 Gershon-related savings in its first year as detailed below:**

- Discontinuation of NCAA Board = £150,000
- Savings from merging Finance Departments = £280,000
- Savings from merging Human Resource Departments = £280,000

- Savings from merging Communications Departments = £300,000
- Savings from merging Information and IT functions = £70,000
- Vacating the 7th floor of Market Towers = £290,000

### The NPSA's overall budget increased to reflect the responsibilities stated above

A breakdown of the budget for the most recent financial year is given below:

<b>Total NPSA budget 2005–06</b>	<b>£35.154 million</b>
Original NPSA budget plus corporate services for all functions mentioned below (IT, HR, facilities, communications, finance and Board)	£19.218 million
NCAS budget	£7.36 million
COREC budget	£5.175 million
Confidential enquiries	£3.034 million
NHS Estates	£0.357 million

By way of comparison, NPSA budget in the years preceding the ALB review was:

<i>Year</i>	<i>Budget</i>
2001–02	£1.763 million
2002–03	£12.12 million
2003–04	£17.552 million
2004–05	£17.108 million

### Pay budget

- The annual projected pay budget (at month 9), including NPSA, NCAS, COREC and NHS Estates is £17.587 million and includes the new salaries under Agenda for Change
- Budgeted pay as a proportion of income is 50%
- WTE cost per budgeted staff is £55,655 (£17,587,000/316)
- This excludes Confidential Enquiries (NPSA simply manages contracts for the enquiries—details of staff pay and staff numbers, if required, must be sourced from the enquiries themselves as these organisations are independent of the NPSA).

### Staff numbers

The ALB review increased staffing also. The breakdown is as detailed below:

<i>Organisation</i>	<i>Staff numbers</i>
Total (post-ALB review) WTE staff budgeted for 2005–06, excluding Confidential Enquiries	316.27

### Breakdown of staff salary

<i>NPSA pre-ALB</i>	<i>2004–05</i>
Under £30,000	40.00
£30,000–£40,000	20.80
£40,000–£50,000	40.97
£50,000–£60,000	25.00
£60,000–£70,000	3.00
£70,000–£80,000	3.20
£80,000–£90,000	3.00
£90,000–£100,000	2.00
	<b>137.97</b>

<i>NPSA post-ALB (all functions excluding Confidential Enquiries)</i>	<i>2005-06 WTE</i>
Under £30,000	77.00
£30,000-£40,000	68.43
£40,000-£50,000	52.73
£50,000-£60,000	23.94
£60,000-£70,000	8.60
£70,000-£80,000	3.00
£80,000-£90,000	3.80
£90,000-£100,000	8.20
£100,000-£110,000	1.00
£170,000-£180,000	1.00
	<b>247.70</b>

- In 2005-06, there are a total of 316,27 WTE in our planned establishment
- As at 31 December 2005, the number of WTE on the NPSA payroll is 247.7

#### Supplementary memorandum submitted by the National Audit Office

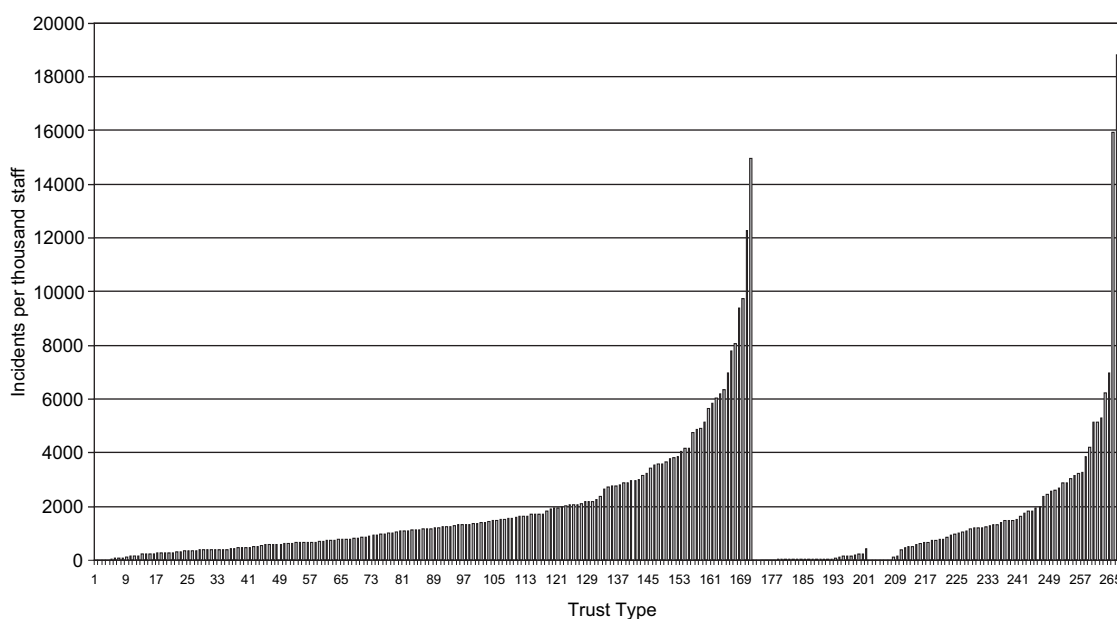
##### *Question 57 (Jon Trickett): Information relating to staff incidents*

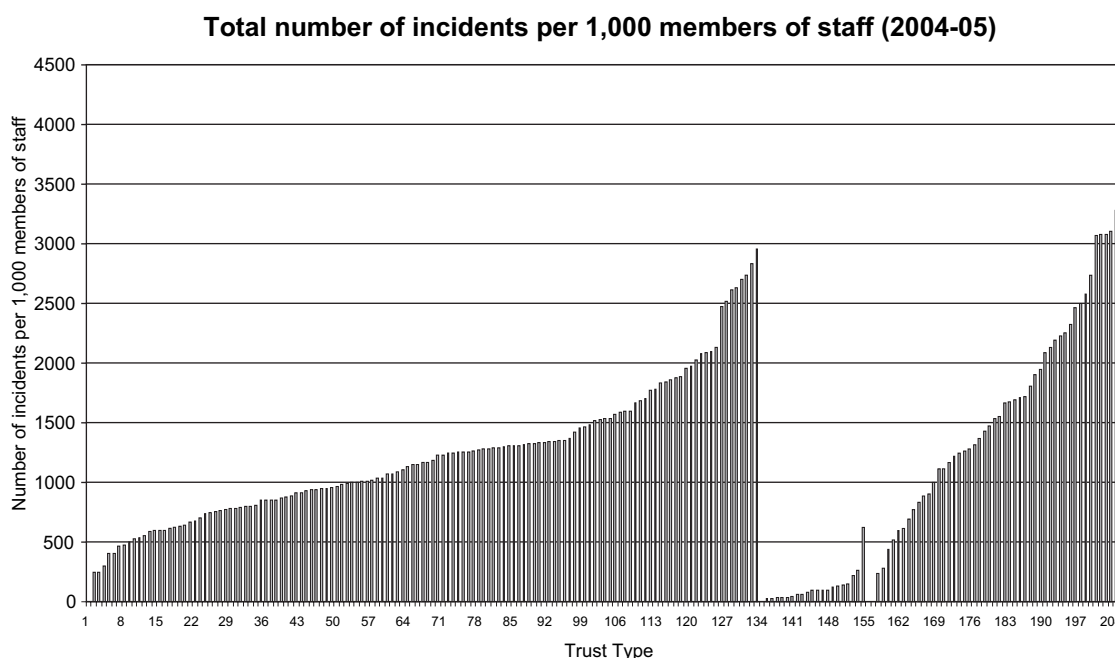
- Revised figure six using the incidents per 1,000 staff—*Number of incidents per 1,000 members of staff.*
- Reported incidents per thousand members of staff compared to star ratings.

#### THE TOTAL NUMBER OF INCIDENTS AND NEAR MISSES PER 1,000 MEMBERS OF STAFF

The total number of incidents and near misses per 1,000 members of staff for 2003-04 (based on responses from 256 trusts) and 2004-05 (based on responses from 212 trusts) are as follows:

**Total number of incidents per thousand staff (2003-04)**





These figures show that there is wide variation in the number of reported incidents and near misses between trusts. The Comptroller and Auditor General’s Report, paragraph 2.6, noted that it is difficult to make year on year comparisons as many trusts have changed their reporting systems. The Report also notes that the Department of Health welcomed the evidence of an increase in numbers of incidents reported as this showed a more complete coverage of reports from across the NHS<sup>1</sup>.

The statistics noted above require careful interpretation as trust use different definitions and report under different reporting criteria. For example we found that some trusts did not differentiate between near misses and incidents and that overall there were far fewer near misses reported than incidents, particularly in mental health trusts. However, statistical analysis shows that the more staff believed that their reporting systems were fair, the closer the ratio of incidents to near misses reported (paragraph 2.13–2.14)<sup>1</sup>.

We also noted that under-reporting was a problem for some trust (35% of executive directors of patient safety told us that under-reporting was a moderate problem and 2% that it was a major problem for their trust. Most (93% had attempted to estimate the level of under-reporting of incidents and near misses (on average 22 and 39% respectively). Also certain types of incidents are more likely to be under-reported. During our visits to trusts managers pointed out that staff were less fearful about reporting a patient fall, as in many cases the attributed cause was not due to direct staff action. In contrast medication errors and adverse drug reactions were under-reported (paragraph 2.16)<sup>1</sup>.

We concluded that at the local level the vast majority of trusts have developed a predominantly fair open and fair reporting culture but with pockets of blame and scope to improve their strategies for sharing good practice. Indeed in our 2005 re-survey we found that local practice had continued to improve with more trusts reporting having an open and fair reporting culture, more trusts with open reporting systems and improvements in the perceptions of the levels of under-reporting (paragraph 6)<sup>1</sup>.

Given the above, we consider that the data on 2004–05, whilst from a slightly fewer number of trusts, is the most up to date and is also likely to be the more robust figure.

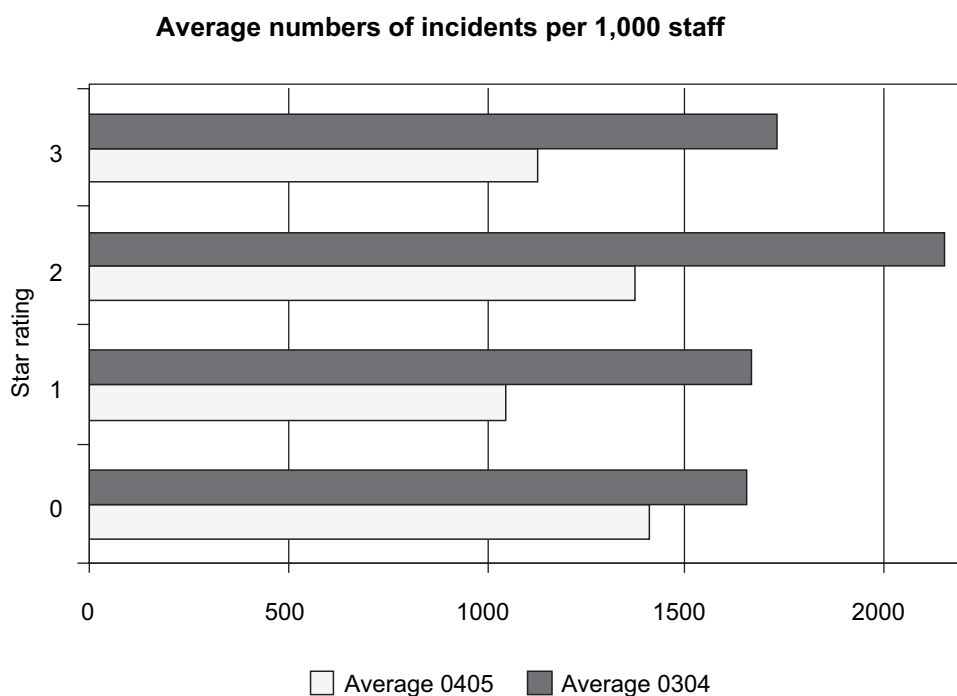
**REPORTED INCIDENTS PER THOUSAND MEMBERS OF STAFF COMPARED TO STAR RATINGS**

We found no statistically significant correlation between star ratings and reported incidents.

This is not particularly unexpected as, partly as explained above, improvements in reporting are still developing and a trust that currently reports a higher level of incidents and near misses is as likely to be a high performing trust as far as developing an open and fair reporting culture, as a poorly performing trust in respect of the safety of patients. The lack of correlation is also likely to be due to the fact that star ratings are awarded following evaluation if a trusts performance against a wide number of performance measures, which do not include the number of reported patient safety incidents.

The ratings, for the financial year 2004–05, assessed performance in meeting targets in areas such as waiting times for hospital treatment, access to GPs and response times of ambulances, as well as management of finances and handling of patients and staff.

<sup>1</sup> The Comptroller and Auditor General’s report (HC 456 Session 2005–06).



Patient safety is covered to a small extent by the response to the patient survey but only as one of many other patient issues. The staff survey also asks questions about staff reporting, but again this is one of a number of issues covered by the questions. The results from the Healthcare Commission's 2004–05 star ratings assessment show an improvement in the performance of the NHS (see below). Details can be found on the Healthcare Commission's website <http://ratings2005.healthcarecommission.org.uk>.