



Health Committee

Select Committee Press Notice

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IMPROVE PATIENT SAFETY DATA, BANISH BLAME CULTURE, AND BUILD ON DECADE OF POLICY INITIATIVES TO REDUCE PATIENT HARM, MPS TELL GOVERNMENT

The NHS has failed to collect evidence about whether patients are any safer after a decade of initiatives to stop harm, says a Health Committee report published today. Significant failings in current patient safety policy and the persistent failure to eliminate the 'blame culture' must also be urgently addressed.

The Committee acknowledges that important steps towards tackling safety have been taken, such as the creation of the National Patient Safety Agency, and that a number of groups have pioneered effective safety initiatives, which the NHS should implement quickly.

However, the report warns that too often NHS boards pay more attention to governance, finances and targets rather than considering patient safety - some have never considered it at all.

Regulation of safety issues has become burdensome and costly, involving too many organisations, whose roles are ill-defined. The Annual Health Check failed to detect notorious cases of bad care, for example at Mid-Staffordshire Foundation Trust, Maidstone and Tunbridge Wells Trust, and Stoke Mandeville Hospital.

Primary Care Trusts must ensure the quality and safety of the services they pay for, yet this happens too rarely. It is unclear what Strategic Health Authorities and Monitor are supposed to be doing.

Harmed patients face lengthy and distressing litigation to obtain justice and the Committee is appalled that the Department of Health still has no timetable for introducing the NHS Redress Scheme, which would mean some patients not having to sue to get compensation.

The delay in introducing technologies proven to improve patient safety is extremely alarming. The Committee also says serious deficiencies remain in the medical training curriculum and this is detrimental to patient safety.

The report recommends:

- Boards and senior management make patient safety the top priority
- Commissioning, performance management and regulation arrangements must be clarified and rationalised to become more effective
- Patient harm rates must be measured by regular reviews of samples of patients' case notes
- The introduction without delay of the NHS Redress Scheme
- Quick implementation of proven technologies which can improve safety
- Ensuring harmed patients and their families always receive full and frank information about incidents of harm
- Enabling front-line NHS staff to use their initiative to improve patient safety
- Better and more explicit patient safety education for healthcare workers

The Chairman of the Committee, Kevin Barron MP, said:

"We are saddened by the avoidable harm that so many patients suffer. While we recognise and are pleased that Lord Darzi's NHS review emphasises safety, it has become clear to us that not all services are safe enough yet. Our report highlights many areas where urgent action is

required, in some cases where it is a life or death situation, and we urge the Government to ensure that everyone in the NHS realises that avoiding harm to patients must be their top priority.”

Ends.

NOTES FOR EDITORS:

The Membership of the Committee is as follows: Rt Hon Kevin Barron MP (Chairman) [L], Charlotte Atkins MP [L], Mr Peter Bone MP [C], Jim Dowd MP [L], Sandra Gidley MP [LD], Stephen Hesford MP [L], Dr Doug Naysmith MP [L], Mr Lee Scott MP [C], Dr Howard Stoate MP [L], Mr Robert Syms MP [C], Dr Richard Taylor MP [IND].

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