English NHS to set up new reporting system for errors

Susan Mayor *London*

The NHS in England is to set up a new, national system for logging all failures, mistakes, and "near misses" in health care and is to move away from the current "blame culture" to one that can learn from adverse events; these changes follow recommendations in a major report published last week.

The report suggests that the health service can learn from industry, particularly aviation, about how to learn from incidents and near misses. It acknowledges that the great majority of NHS care is of a very high clinical standard and serious failures are uncommon.

It points out, however, that up to 850 000 adverse healthcare events occur each year in the NHS hospital sector alone. Lack of systematic collection of information is seen as a major block in helping the NHS to improve its management of mistakes.

At the moment, NHS organisations are required to have incident reporting systems, but there is little consistency in these around the country and there is no single system for bringing information together.

The report recommends the introduction of a mandatory reporting scheme for adverse healthcare events and near misses based on standardised reporting systems. It also suggests the setting up of a single, overall database for analysing and sharing lessons from incidents, as well as litigation and complaints data. This will be used to identify common factors and develop recommendations to reduce risks of events in the future.

The chief medical officer, Professor Liam Donaldson, who chaired the expert group that developed the report, has said that the new national system will be in place by the end of this year.

Professor Donaldson said: "At the moment there is no way of knowing whether the lessons learnt from an incident in one part of the NHS are properly shared with the whole of the health service. We must stop history from repeating itself, as it sometimes seems to do.

"The aviation and other industries have systematic approaches to analysing mistakes and failures, and learning the lessons. The NHS needs to apply what is known from those sectors to its own efforts to assure quality of services to patients."

The current organisational culture of the NHS is also blamed for the lack of proactive and open management of adverse events. The report suggests that the NHS tends towards a "blame culture," which can encourage people to cover up errors for fear of retribution and act against the identification of the true causes of failure by focusing heavily on individual actions and largely ignoring the role of underlying systems.

It recommends a move to a more open culture in which errors or service failures can be reported and discussed.

Dr Charles Vincent, reader in psychology at University College London and member of the expert group, explained why this change needs to occur: "Most doctors have patients' interests at heart and do their best. They think that this must surely be enough. However, this misunderstands the key point being made about safety by the report. Airlines aren't safe just because pilots do their best—they base their safety on the whole system.

"The recommendations made about changing the culture of the NHS recognise that safety is partly based on the efforts of individuals but is partly affected by the wider organisational network." (See pp 1683, 1738.) □

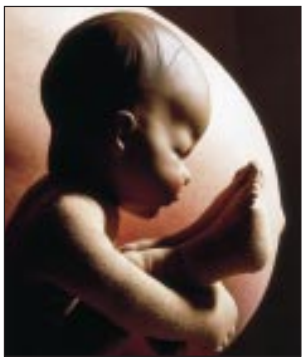
An Organisation with a Memory is available from the Stationery Office, PO Box 29, Norwich NR3 1GN (tel 0870 600 5522), price £14.50.

Full story in News Extra at bmj.com

Doctors need more training in delivering breech babies

Mark Silvert *BMJ*

The single and most avoidable factor in causing stillbirths and deaths among breech babies is suboptimal care given in labour, according to the seventh annual Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI).



RUTH JENKINSON/MIDIRS/SPL

Breech babies: doctors should be better trained in fetal surveillance

In cases where the cardiotocograph was available for review, there was clinical evidence of hypoxia in all but one case before delivery, and delays in staff response to fetal compromise occurred in nearly three quarters of cases. These delays ranged from 30 minutes to 10 hours.

The report, which applies to babies in England, Wales, and Northern Ireland, said that a registrar was the practitioner most likely to be involved in the labour and delivery of breech babies. Less than a fifth of these labours had involvement from more senior staff, and consultants were informed in only half of these cases before delivery. Inexperience at the time of delivery exacerbated the risk for an already hypoxic baby in some cases.

Pathology reviews confirmed the clinical findings that hypoxia was the commonest cause of death. Trauma was the sole cause in one case.

Less than a quarter of the postmortem examinations included a systematic and comprehensive examination of factors relevant to the death of a breech baby born vaginally.

In the light of these findings, the new report recommends that trusts should ensure that all staff are skilled in fetal surveillance and that the most experienced available practitioner is involved and present at a vaginal breech delivery.

Structured simulated training is advocated for all staff who may encounter a vaginal breech delivery. Trusts have also been told that they need to ensure good documentation of anaesthetic events, including the time of the decision to deliver, when the patient reached the operating theatre, when the anaesthetist was informed, and when the baby was delivered.

One of the recurrent themes noted by the inquiry was the problem with the use and interpretation of cardiotocographs. □

A full copy of the 7th annual report can be obtained from the CESDI Secretariat, Chiltern Court 188 Baker Street, London NW1 5SD (tel 020 7486 1191), price £6.

Ombudsman slams deputising service

Zosia Kmietowicz *London*

General practitioners in England have been advised to monitor the deputising service they use more closely after complaints to the health service ombudsman, Michael Buckley, showed that the biggest of the private companies provided a "totally unacceptable" service.

Although Mr Buckley's office received only three complaints about Healthcall (and the organisation had taken steps to remedy the criticisms), investigations showed the service to be substandard.

A woman in Gateshead had to wait nearly three hours for a doctor to arrive after calling Healthcall. By the time a doctor did appear, the woman was unconscious and later died.

The report can be accessed at www.ombudsman.org.uk □

Full story in News Extra at bmj.com