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VIEWS AND REVIEWS

ACUTE PERSPECTIVE

David Oliver: Preventing a Gosport repeat

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In the wake of this June's inquiry report on the sometimes preventable or needlessly distressing deaths of 451 patients at Gosport War Memorial Hospital in the 1990s,[1] a November Commons statement by the health secretary set out policies aiming to prevent a repeat and to improve wider healthcare safety.[2]

I broadly welcome such government attention, but the devil is in the detail. Ultimately, the only way to improve safety and prevent further scandals is through the culture and solutions of local organisations.[3] Reports on other recent mass care failings have shown that external regulation can be late in recognising them.[4-6] A recent King's Fund report on the Care Quality Commission questioned its record in improving safety rather than describing or rating it.[7]

Too often patients, families, local media, and staff have had to speak up for problems to be identified and action taken. This happened at Gosport, where nurses' concerns were repeatedly ignored, dismissed, or suppressed in what the inquiry found to be an overly hierarchical culture.[1 8] We need conducive systems and a just culture, where open, candid flagging of problems is encouraged and required. This is now the official view among central NHS leadership and professional regulators.[9 10]

The events at Gosport, where several contributory factors aligned, are probably less likely two decades on. But I doubt that any of the individual issues raised has been resolved in every NHS service.

Gosport was a small community hospital, off the site of the main district hospital and without its onsite senior specialist doctors. This isn't inherently bad: hundreds of UK community hospitals provide care for patients who don't need the full facilities of a general hospital. Patient outcomes and experience can be good, the care more personalised and local.[11 12] Such units are often valued by the public.

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However, in my view, community hospitals, operated by a far wider variety of providers than general hospitals, have had comparatively little regulatory scrutiny, standardisation, or measurement of their activity and performance.

Jane Barton, the doctor whose decisions featured most prominently in the Gosport inquiry, worked as a clinical assistant. Her case raises an issue of training and supervision for doctors in such roles and of professional accountabilities for the supervising consultants if based on another site.

The inquiry also concerns the safe, skilled prescription and administration of opioids in symptom control and in the palliative care of patients recognised as terminally ill, including the safety of syringe pump devices (those used at Gosport are no longer permitted).[13] Sadly, the inquiry found that several patients who were not terminally ill were labelled as dying or given very large doses of opioids. This in turn raises the issue of doctors' confidence in accurately recognising the dying phase and discussing it openly and sensitively with patients and families.[14] At Gosport it seemed that patients deemed to have little chance of recovery didn't always know that this decision had been made or why.

Much has changed since Gosport, including legislation and appointed posts to protect healthcare whistleblowers,[15] establishment of the CQC and the Healthcare Safety Investigation Branch,[16] a national "learning from deaths"[17] programme and a push for medical examiners of deaths,[18] and now a requirement for a national healthcare safety lead—and leads in each hospital, openly reporting how they're acting on what they learn.[2 19]

On balance, it would be far harder these days for such care failings to happen over such a prolonged period—but, as workload rises and workforce gaps grow, complacency could kill. Let's make sure that it doesn't.

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