Can we tell whether hospital care is safe?

One of the most troubling implications of Sir Robert Francis's reports on Mid Staffordshire (Mid Staffordshire NHS Foundation Trust Inquiry, 2010; Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013b) is that similar failings might be occurring elsewhere, undetected and uncorrected. That the deficits in the quality of care at Stafford should have gone unnoticed and unaddressed for so long has caused widespread soul-searching. It prompted the government to commission a review of 14 other hospitals 'to take a fresh look at these organisations, many of which have been inspected many times before and granted a clean bill of health, despite the continuing high mortality rates' (Keogh, 2013), which 'uncovered previously undisclosed problems in care' (Keogh, 2013). If, as the Keogh review suggests, existing methods cannot always give us an accurate picture of risk and harm, then how can we tell whether patients are safe?

Warning signs

At Stafford, Francis catalogued a succession of warning signs of looming catastrophe that somehow went unheeded, including hundreds of formally submitted incident reports about understaffing, the content of complaints from patients and relatives, and repeated attempts by clinical and other staff to raise concerns. But there are also indications in his reports of the conditions that could allow these signals to be ignored.

The second inquiry found a 'management failure to remedy the deficiencies in staff and governance that had existed for a long time,' such that 'statistics and reports were preferred to patient experience data, with a focus on systems, not outcomes' (Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013b). Managers exhibited a preference for sources of data that showed them in the most favourable light over evidence for the existence of weaknesses or shortcomings – an approach that the authors have elsewhere dubbed 'comfort-seeking' rather than 'problem-sensing' behaviour (Dixon-Woods et al, 2014a).

The organizational culture of Stafford made it less likely that problems would be identified and acted upon early. Similar patterns of behaviour have been found in the gestation of other disasters, inside and outside health care: as Macrae (2014) argues, 'disasters are essentially organised events', characterized by 'shared beliefs, collective assumptions, cultural norms and patterns of communication across organisations that shape what information is attended to and how it is interpreted and communicated – and most importantly, what is overlooked, discounted and ignored'.

Quality measures did not work

It was not just those inside Mid Staffordshire Trust who failed to act promptly in response to poor care quality: regulators, commissioners, forums representing patients and other external actors also failed either to hear or to act on the clamour of warning bells.

This points to a further disturbing feature of Stafford: the ambiguous and misleading image of the state of care at the hospital offered by some measures of quality then in use. Thus in 2007, in the midst of the tragedy at Stafford, the then regulator of acute care providers in England rated the hospital 'good to fair', naming it one of the year's four 'most improved' hospital trusts (Healthcare Commission, 2007). By November 2009, based primarily on adjusted mortality data, a hospital league table was suggesting that Stafford was one of the country's 10 safest hospitals (Hawkes, 2010).

The importance of narrative

Good intelligence about what is actually going on in hospitals, then, can be trumped by the solace to be found in high-level measures of uncertain scientific standing. Despite their shortcomings, regulators, managers and clinicians may be reluctant to look beyond them. So what might we do in response? Francis himself hints at some of the possibilities when he calls for 'greater attention […] to the narrative contained in, for instance, complaints data, as well as to the numbers' (Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013b), with 'directors personally listening to complaints, concerns and suggestions of patients and staff, and being seen to act on them' (Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013a). The potential of such 'softer' forms of intelligence on quality and safety has long been vaunted. But realizing this potential in practice remains difficult, not least because such intelligence often takes the form of forbidden, 'fugitive' knowledge that is elusive, is based on slippery evidence, and may be dangerous both for those who reveal it and those to whom it is revealed.

Trusting information

Recent research, however, does offer managers and clinicians some guidance as to how they might do better. There is increasing evidence that the knowledge of staff working at the sharp end of care offers an important source of insights on the realities of care quality (Dixon-Woods et al, 2014b). Accessing such insights, however, may be challenging and, too often, senior managers are inclined to conflate mechanisms for gathering intelligence with mechanisms for holding staff to account.

For example, a recent study the authors conducted of executive walkrounds – held up as a crucial way of connecting ward and board, leading for quality, and gathering understanding of those sharp-end realities – shows how the temptation to use them as a means of surveillance risks undermining the very benefits that walkrounds offer (Martin et al, 2014). For sharp-end staff to feel comfortable in disclosing the risks and challenges they face in their everyday practice, they

need to feel sure that the confidences they impart will not be used to punish them.

Then there is the challenge of interpretation. Here, there are no obvious markers of good interpretation or means of filtering out the noise; rather, the evidence suggests that there is no substitute for persistence, reflexivity, and above all an unrelenting commitment to question the taken-for-granted, and to value contradictory evidence. As Weick and Sutcliffe (2003) put it in their influential analysis of the earlier paediatric heart surgery scandal at Bristol Royal Infirmary: 'challenge easy explanations.' Above all, it is about 'working continuously to test, disconfirm and challenge current assumptions about safety, and identify where current knowledge and beliefs are becoming outdated or are out of synch with organisational reality' (Macrae, 2014).

These are hugely demanding mandates for clinicians and managers. Making sense of soft intelligence in this way – searching for the contradictory signs that will often turn out to be false positives – is hard work; the task of maintaining a vigilant and reflexive mindset when all seems well should also not be underestimated. Arguably even more challenging is speaking up about issues that others do not perceive, an undertaking that requires courage and self-confidence given the risks it entails to personal reputation and future prospects. Dealing with issues raised invidiously, or raised when there is no reasonable or sound evidence for the concern, can consume huge resources and do much damage to individuals and organizations.

Personal responsibility in an organizational setting

This points to perhaps the most important lesson of all from Stafford. While speaking up may be a personal and professional responsibility, it is much less hard to fulfil in organizations where systems and culture are supportive. Providing, gathering, analysing and acting on intelligence is easier where systems are geared towards caution rather than complacency, where staff are given space to discuss problems openly, and where lone individuals who perceive problems are listened to and supported (whether they turn out to be right or wrong) rather than ignored or vilified: these are the organizations where individual and organizational responsibilities are aligned, and which thus perhaps stand the best chance of avoiding the path that can lead to tragedy. Designing effective systems and inculcating supportive cultures takes time, but it is the most important professional and managerial responsibility of all. BJHM

KEY POINTS

- The experience of Mid Staffordshire shows how hard it can be to know whether patients are safe.
- Established metrics can mislead, and managers may be inclined to ignore unpalatable information.
- There is scope for making better use of 'softer' forms of intelligence on the quality of care.
- Gathering and making sense of such intelligence requires sensitivity, vigilance and persistence.
- Health-care organizations must work to provide settings that encourage rather than penalise openness and challenge.

Graham P Martin/
Mary Dixon-Woods
Professor of Health Organisation and Policy/
Professor of Medical Sociology
Department of Health Sciences
University of Leicester
Leicester LE1 6TP
(gpm7@le.ac.uk)

Dixon-Woods M, Baker R, Charles K et al (2014a) Culture and behaviour in the English National Health Service: overview of lessons from a large multimethod study. *BMJ Qual Saf* **23**(2): 106–15 (doi: 10.1136/bmjqs-2013-001947)

Dixon-Woods M, Minion JT, McKee L, Willars J, Martin G (2014b) The friends and family test: a qualitative study of concerns that influence the willingness of English National Health Service staff to recommend their organisation. *J Royal Soc Med* **107**(8): 318–25 (doi: 10.1177/0141076814532392)

Hawkes N (2010) Patient coding and the ratings game. *BMJ* **340**: c2153 (doi: 10.1136/bmj.c2153)

Healthcare Commission (2007) *The annual health check 2006/07: a national overview of the performance of NHS trusts in England.* Healthcare Commission, London

Keogh B (2013) *Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report.* NHS, London

Macrae C (2014) Early warnings, weak signals and learning from healthcare disasters. *BMJ Qual Saf* **23**(6): 440–5 (doi: 10.1136/bmj.c2153)

Martin GP, Ozieranski P, Willars J et al (2014) Walkrounds in practice: corrupting or enhancing a quality improvement intervention? A qualitative study. *Jt Comm J Qual Patient Saf* **40**(7): 303–10

Mid Staffordshire NHS Foundation Trust Inquiry (2010) *Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust.* The Stationery Office, London

Mid Staffordshire NHS Foundation Trust Public Inquiry (2013a) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry.* The Stationery Office, London

Mid Staffordshire NHS Foundation Trust Public Inquiry (2013b) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: executive summary.* The Stationery Office, London

Weick KE, Sutcliffe KM (2003) Hospitals as cultures of entrapment: a re-analysis of the Bristol Royal Infirmary. *Calif Manage Rev* **45**(2): 73–84 (doi: 10.1225/CMR249)