

Secret report revealed faults safety system for hospitals, but ministers failed to act

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The government was warned two years ago in a secret report that its system of monitoring hospital safety was seriously flawed.

Although ministers commissioned the report, they failed to act on its findings that the system was unreliable because it relied on hospitals to rate their own safety records. According to the report a 'culture of fear' exists within the management of the NHS and prevents managers from admitting when mistakes have been made. The report was obtained under freedom of information legislation. It casts doubt on the claims that a series of deaths in NHS hospitals are merely isolated incidents.

Last November Baroness Young, the chairman of the government's health watchdog, resigned because she was unhappy with the system.

The report, by Joint Commission International, highlights 'significant flaws' in the NHS safety system. There is no real means of improving poorly performing hospitals, and when hospitals are found not to be complying with standards there is a 'light-handed' approach to having them improve.

The report also found that two thirds of external regulators' assessments did not agree with those of the hospitals themselves and that the Department of Health did little to try and remedy safety failures.

A 'pervasive culture of fear' means managers are often reluctant to disclose details of poor performance. In November, Basildon and Thurrock trust was said to be one of nine which rated themselves as good, only to be found to have the worst death rates in the country. Poor nursing care, filthy wards and lack of leadership led to the deaths of 400 patients a year.

Figures compiled by the Care Quality Commission, the health watchdog, showed that death rates at the Essex trust were a third higher than they should have been.

Concerns about practices at the hospital were raised a year earlier, but an internal investigation found nothing wrong.

Carole Watts, who leads the clinical negligence team at Pictons, says that "it is disappointing that this report has been kept secret from the public for two years and that the warnings that were highlighted have not been acted upon.

It is unacceptable that hospitals can rate their own safety records and a system of independent review needs to be in place to ensure that safety standards in hospitals are met. Where a hospital falls short, tougher measures are required to ensure safety standards are improved and maintained at an acceptable level. It is important that the NHS encourages a culture of openness to ensure that when mistakes occur these are reported by management so that steps can be taken to prevent the same mistakes occurring again to protect patient safety."

If you would like to speak one of our clinical negligence solicitors, please contact Pictons' Clinical Negligence Team on 0845 2637505 or email carole.watts@pictons.co.uk