Are targets within the NHS harming patient safety?

According to a recent study, the need to succeed financially and meet targets receives greater attention in risk management documents than patient safety and staff workload.

Within the National Health Service (NHS) in England, keeping patients safe from unintended harm is a significant issue and is fundamental for both the patient and the delivery system providing the treatment. Within the NHS, as in healthcare within other developed countries, there is a demonstrably poor record on patient safety.

The scale of the problem

The scale of the problem is significant. Adverse events are “incidents in which a patient is unintentionally harmed by medical treatment”. A retrospective case note study in two NHS hospitals found 11 per cent of patients suffering adverse events, almost half of which were deemed preventable. In a similar study in a large NHS teaching hospital, 9 per cent of admissions had at least one adverse event, of which 31 per cent were deemed preventable. That study showed that 15 per cent of the adverse events led to impairment or disability that lasted more than six months, and 10 per cent contributed to the patient’s death. The result for patients was a prolonged period of treatment leading to an increased length of stay by 8 days on average. In a more recent prospective study focusing on an admission ward, the rate of adverse events was 11 per cent and potential adverse event or near miss to be 15 per cent.

The Department of Health’s Chief Medical Officer recognised the seriousness of the issue in a landmark report. A consequence of this report was the establishment of the National Patient Safety Agency (NPSA), which developed a national reporting scheme for errors and near misses. The Department of Health (DoH) issued a further report as part of the drive to improve patient safety, and set out “core standards” of safety within the “Standards for Better Health”. All health care providers must meet these standards. An independent body, the Healthcare Commission, monitors compliance with all the standards annually.

Given the serious nature of the problem and the considerable policy initiatives, it would be expected that significant progress would have been made in measuring and reducing the level of adverse events within NHS hospitals. However, the best intentions of making “safety first” have become a casualty of other more pressing success factors, such as waiting times and financial balance sheets.

The study

The results of the latest study supported the proposition that the boundaries of financial and target failure featured more in the Assurance Frameworks than the other boundaries. The inclusion of risks related to staff was very limited. Patient safety did feature in general terms, and more specifically in regard to infection control which has nationally set targets to be achieved. Aspects of patient safety derived from patient safety campaigns such as “medicines management” or the “deteriorating patient” did not feature. Given the known rate of adverse events and harm that occur in NHS hospitals, it is surprising that they did not feature significantly. Whilst “quality” was used in the document, it was found to be a general term without any meaningful definition.

We discussed the results with the Director responsible for patient safety in one of the study hospitals. They confirmed the focus on targets and achieving the requirements of Standards
for Better Health. That focus had helped the hospital to be rated as “excellent” by the Healthcare Commission for both “quality of services” and “use of resources”. Although the Assurance Framework is the key risk management document for the Trust Board according to the DoH, other reports and meetings were used in that Hospital to consider aspects of patient safety and staffing.

Where financial and target failure is more clearly articulated, the pressure on the operating point to keep away from those boundaries means that the system will be operating closer to the boundaries that receive more limited consideration. This focus draws attention to potential blind spots or instances of normalization where the system may be more vulnerable to breaching the marginal zone.

The NHS hospitals studied do not appear to use the Assurance Framework to focus their efforts on setting a safe context for front line clinical treatment. Extant literature suggests that the pressure on the operating point at times of peaks in patient demand is a risk issue for both staff workload and patient safety. Human error within the context of unsafe systems is a well-known phenomenon. The risks associated with high volumes of activity, their impact on staff and other patient safety issues, do not receive the same degree of attention as finance and targets in the key risk management document for Trust Boards.

The management focus in the Assurance Frameworks is predominately on the corporate risks associated with financial and target failure. These are risks more associated with an impact on the organisational management and less on the clinical safety of patients. The DoH, at the time of this study, had issued an “Operating Framework” which focused on financial management and targets with almost no mention of patient safety. It is, therefore, perhaps not surprising that a DoH mandated document for risk management, the Assurance Framework used by Trusts, focused on the risk related to the priorities set by the higher authority.

Drug errors are one of the most common adverse events that occur to patients. The fact that “medicines management” or “prescribing errors” were not included in any of the Assurance Frameworks illustrates that the focus of the documents was on corporate rather than patient or clinical risk. Given the nature of hospital work, it would not be unreasonable to expect that risks to patients from prescribing errors be regarded as a “principle risk” to the achieving the objectives of the hospital.

The NHS hospitals studied adopt an approach to risk management at board level, which focuses predominately on the corporate risk related to finance and improvement targets. Such “active” priorities have to be balanced by the “chronic” or maintenance priorities of patient and staff safety. Without this balance, patient safety will remain a casualty of the emphasis on meeting other priorities and targets. The current measurement systems appear to be a product of the productivity and efficiency culture. This is inadequate in a healthcare context. Given the primary function of a hospital is first to “do no harm” to patients, there is an imbalance in the way priorities are set, measured and monitored. Our pilot study supported the initial proposition that the failure boundaries for finance and targets would be more clearly set out and monitored than those associated with safety.

At an organisational level, a conceptual four boundary model of a safe working envelope can bring to mind the concept of an “operating point” and the conflicting pressures that can occur to move the operating point into the marginal zone with the potentially to breach a boundary. If the wider and dynamic pressures, such as the pressure created by peaks in demand, are not taken into account when making decisions then senior managers are in danger of developing hidden conditions that create the environment for accidents to occur. By developing four, rather than three, boundaries, we are taking account of the particular circumstances of a politically led NHS with a very strong target and financial control culture which can place substantial pressure on the operating point. The idea of compensating actions constituting the marginal zone, with the potential for such actions to be measured, can be developed and tested as an indicator of the resilience concept.
Implications for practitioners

For practitioners, the conceptual model will assist them in recognising the conflicting pressures that they work with. Such a resilience model may also stimulate the setting of boundary measures and finding a mechanism to monitor the location and stability of the operating point at various levels within a hospital. This could potentially be done through a combination of setting boundary marking standards for all four boundaries, examining the nature and frequency of compensating actions, and learning from incident reports. The Assurance Framework could be developed to provide a more balanced perspective on risks and hence design greater resilience into the system.

April 2011.

This is a shortened version of “Patient safety: a casualty of target success?”, which originally appeared in the *International Journal of Public Sector Management*, Volume 23, Number 5, 2010.

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