Of Culture, Leadership and Quality

During my time as Commissioner, I have repeatedly emphasised the importance of culture in achieving a truly consumer-centred health care system. Good cultures – cultures which facilitate safe and effective care – are ones which:

- empower staff, and patients, to raise concerns and ask questions;
- support staff to learn and develop in order to continuously improve their skills;
- recognise and accept where something has gone wrong, and learn from mistakes; and
- acknowledge the value of involving patients in planning, providing and assessing care.

The idea that culture is critical to achieving high standards of medical care has been recognised in the recently released report of the National Advisory Group on the Safety of Patients in England. The Advisory Group, led by Professor Don Berwick, was tasked with distilling the learnings identified in the aftermath of the events at Mid Staffordshire NHS Foundation Trust, and providing suggestions for a way forward.

In 2009 it was revealed that between 2005 and 2009 there had been serious failings at the facilities operated by the Mid Staffordshire Trust. Investigations have found that the most basic elements of patient care were neglected. Among other things, food and drink were left out of patients' reach leading to serious dehydration, patients were left sitting in their own faeces for hours, hygiene standards were appalling, and misdiagnosis of medical issues was common.

The Advisory Group's main message in their report is that, in most cases, patient safety problems are caused, or at least contributed to, by organisational culture. The Advisory Group's recommendations focus on the need for culture change, noting that "in the end, culture will trump rules, standards and control strategies every single time, and achieving a vastly safer NHS will depend far more on major cultural change than on a new regulatory regime." The report also emphasised that all staff had a role to play in effecting this culture shift, but that those in leadership positions would play a particularly important part, noting that "culture change and continual improvement come from what leaders do, through their commitment, encouragement, compassion and modelling of appropriate behaviours."

One of the cases that I have recently published demonstrates the way culture can affect the safety of patients.

A 78-year-old woman was referred acutely by her GP to a hospital with concerns about vomiting and dehydration, an irregular pulse, and a groin lump. The referral contained this history and queried the presence of a hernia. When she arrived at the hospital, the woman was reviewed by a junior registrar and a consultant and a provisional diagnosis of an abdominal malignancy was made. The next day, the registrar spoke to the woman's GP, who again queried whether the woman had a hernia, and expressed concern that not all of her symptoms were explained by the provisional diagnosis. However, the registrar did not pass those concerns on to the consultant.

The woman deteriorated over the next few days, and at one stage went 27 hours without medical review. She eventually went into cardiac arrest. Following resuscitation, an operation confirmed a diagnosis of incarcerated femoral hernia. Sadly, the woman died from the severe hypoxic brain injury she suffered during the cardiac arrest.

My investigation of this complaint identified a number of failures by the clinical staff involved in the woman's care. There was an apparent unwillingness by the registrar to ask for help or advice from

senior clinicians. The concerns of both the woman's GP and her family were not listened to or dealt with appropriately. The processes for conducting rounds and handovers hampered the flow of information between the various teams involved in the woman's care. Nursing staff who asked for medical review did not feel they could escalate their request when timely review was not provided. Staff told my Office that they felt pressured by low staff numbers, time and resource constraints, and a lack of available senior clinicians. Ultimately, many of those failures had their roots in the prevailing organisational culture.

Subsequently, the DHB has implemented changes to their rosters and systems so that staff are better supported to do their job. Forms, policies and procedures have been created or adjusted to avoid similar failings in the future. Rosters have been reworked. Action has been taken to ensure a better interface between clinical teams, and the case has formed the basis of training programmes and discussions which will ensure the lessons learned are applied.

Indeed, applying "lessons learned" is what the Advisory Group's report into Mid Staffordshire is all about. But do the lessons from Mid Staffordshire apply in New Zealand? Could what happened there, happen here? As illustrated above, poor care can happen anywhere. But do I think it is as likely to happen in such a systemic and widespread way here? No, I don't. Quite aside from the relative size of the health system and the population in the United Kingdom compared to New Zealand, I would suggest that the approach to patient and consumer rights in this country is somewhat unique. We were the first country in the world to legislate for the rights of health and disability consumers. The resulting Code of Health and Disability Service Consumers' Rights is the standard to which all providers are held and against which complaints to my Office are measured.

In the margins where we do not do well, culture often plays a part. It is seen in the failure to speak up, to raise a question, to make the connection, to listen – to patients, family, colleagues. That is why I've been focussed on cultures that empower people; cultures that embody transparency, engagement, and seamless service as they put consumers at the centre of services.

One senior NHS official reflecting on the Advisory Group's report last week said "NHS welcomes the focus on growing a culture which puts patients first, engages and empowers patients and carers, supports transparency and learning and takes responsibility for poor care." New Zealand's Code of Health and Disability Service Consumers' Rights embodied a legislative shift of focus to the patient – our culture followed. Enduring success will require ongoing vigilance. This will ensure that we continue to narrow the margins where we fail our patients.

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