Department of Health

From the Rt Hon Jeremy Hunt MP
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Health and Care Partnership

Dear colleagues,

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Strengthening patient safety in the NHS

We share an ambition to make the NHS the safest healthcare system in the world and today is a key milestone on our journey to realising this ambition. I want to take this opportunity to draw your attention to a series of important announcements that have been made today to contribute to this.

Only last week the respected Commonwealth Fund ranked the UK as the best healthcare system in the world. We can all be particularly proud of the fact we moved from seventh place to be ranked first for patient-centred care and also came top for safety.

Nonetheless, there is more to do. Importantly, in order to respond to continued staff and public concern about whether we are doing all we reasonably can to create the open culture that we know is essential to safe patient care, I have today announced that Sir Robert Francis QC will lead an independent policy review into whistleblowing and creating a culture of openness and honesty in the NHS.

I believe it is important that we hear the voices of those who say they have been harmed and learn lessons for the future. The review will therefore look at what further action is necessary to protect individuals working in the NHS who speak out.

The review will provide independent advice and recommendations on measures to ensure that those working in the NHS can raise concerns with confidence that they will not suffer detriment as a result and to ensure that where NHS whistleblowers are mistreated there are appropriate remedies for staff and accountability for those mistreating them. The review will also consider the merits and practicalities of independent mediation and appeal mechanisms to resolve disputes on whistleblowing fairly.

Robert Francis will issue a call for evidence from whistleblowers, frontline staff, NHS employers, trade unions and regulators amongst others and will use this evidence to spot emerging trends and issues. I urge you to take the opportunity to submit evidence from your own organisation's perspective.

Also today, for the first time, the NHS has published a series of patient safety indicators for adult and paediatric hospital wards, including mental health and community hospitals. The data has been published on a new safety section on NHS Choices, which lists hospitals' performance against key patient safety indicators of pressure ulcers, safety reporting, infection control, blood clots and staff and patient feedback. Importantly, it includes publication of nurse, midwife and care staffing level data. Publishing staffing data at a national level was a key commitment in the system-wide response to the Public Inquiry into the poor standards of care at Mid Staffordshire NHS Foundation Trust and is major step forward.

The staffing data shows the percentage of nursing hours filled as planned in May. This is then broken down between day and night hours, and between registered nursing and midwifery staff and care staff (for example, healthcare assistants). I'm delighted that the Chief Nursing Officer for England is now leading others to go even further and plans to develop a comparable staffing indicator so that, in future, trusts can be rated as red, blue or green for their staffing. We must not underestimate the power of bringing such an unprecedented level of transparency to this staffing information. It will play a key role in helping to drive a new culture of openness across the system.

Finally, I want to draw your attention to a new campaign that brings all of our work to improve patient safety together and help realise the ambition of making the NHS the safest healthcare system in the world. We need to give patients confidence that we are doing all we can to ensure that the care they receive will be safe and effective at all times. We all recognise that healthcare carries inherent risk and while everyone working in the NHS works hard every day to reduce this risk, harm still happens. Some is avoidable but most isn't. We must be open with patients about the potential for things to go wrong and for people to get hurt, and most of all, we must continuously learn from what happens in order to improve.

Organisations are being asked to develop a plan that describes how they will reduce harm and save lives, by working to reduce the causes of harm and take a preventative approach. They will be asked to identify two or more national patient safety priorities, such as medication errors or deterioration of patients, and two or more local priorities to focus on in their plans. As part of this work, they will be engaging local communities, patients and staff to ensure that the focus of their plan reflects what is important to the community they serve. They will make public their plan and update regularly on their progress against it.

Harnessing the talent and enthusiasm across the system will help make enduring changes to improve safety, halve avoidable harm and halve the costs of harm. Most

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importantly it will make a positive difference to the people we care for and save 6,000 lives over the next three years.

I have announced the first 12 trusts who have already signed up to the campaign today. These are:

- Central London Community Healthcare NHS Trust
- Frimley Park Hospital NHS Foundation Trust
- NHS Nottingham University Hospitals NHS Trust
- North Bristol NHS Trust
- Oxleas NHS Foundation Trust
- Royal Berkshire NHS Foundation Trust
- Royal United Hospital Bath NHS Trust
- Salford Royal NHS Foundation Trust
- Sheffield Teaching Hospitals NHS Foundation Trust
- Staffordshire and Stoke on Trent Partnership NHS Trust
- Taunton and Somerset NHS Foundation Trust
- 2Gether NHS Foundation Trust

More information about the detail of the plans that organisations are developing and the support available to them from across the health and care system can be found at www.signupttosafety.nhs.uk

I'm sure you'll agree that while we have more to do, today marks real progress and a sign of what we can achieve.

JEREMY HUNT