

Independent safety investigation needed in the NHS

October 31 2014

The NHS should follow the lead of aviation and other safety-critical industries and establish an independent safety investigation agency, according to a paper published today by the *Journal of the Royal Society of Medicine*. The authors say the NHS has no consistent approach to investigating safety issues, and remains dependent on costly one-off independent or public enquiries to learn from the most serious failures, such as those contributing to the tragedies at Mid Staffordshire.

Lead author Carl Macrae, Health Foundation Improvement Science Fellow, Imperial College London, said: "Inquiries can have considerable impact and provide much-needed public explanation after terrible events. However, each investigation starts anew and struggles to develop a methodology and approach, rather than building on systematic and established methods of safety investigation." He added: "Inquiry teams are short-lived and are dissolved once the report is complete; they therefore have no capacity to independently review progress against recommendations."

Safety-critical industries such as aviation, shipping and the railways all face the risk of major failures causing tragic loss of life. Each of these industries is served by an independent and permanently staffed organisation that is explicitly charged with investigating serious safety risks and major failures. A similar agency is needed for the NHS, say the authors, describing a lean organisation operating with a relatively small budget, ready to initiate investigations within hours when required. Charles Vincent, Health Foundation Professorial Fellow, University of



Oxford and co-author of the paper, said: "First and foremost such an agency needs to be authoritative and open in its practices and recommendations", adding that the agency should be charged with independently monitoring the implementation of recommendations, over years if necessary.

Macrae added: "Patients and the public deserve better than the current models of investigation in the NHS, none of which have the remit, capacity or authority to routinely drive system-wide and top-to-bottom learning. Establishing a truly independent, expert investigative body would allow the NHS to rigorously investigate and routinely improve <u>safety</u> across the entire healthcare system."

More information: Learning from failure: the need for independent safety investigation in healthcare (DOI: 10.1177/0141076814555939) by Carl Macrae and Charles Vincent will be published by the *Journal of the Royal Society of Medicine* on Friday 31 October 2014.

Provided by SAGE Publications

Citation: Independent safety investigation needed in the NHS (2014, October 31) retrieved 16 June 2024 from <u>https://medicalxpress.com/news/2014-10-independent-safety-nhs.html</u>

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