

## Letter to the people of England

Your government and the leaders of the English National Health Service did me the honor earlier this year of asking me to assemble and chair an Advisory Group to recommend some important actions that leaders, clinicians, professional bodies, government agencies and others could take to improve the quality and safety of care in the NHS.

I took that assignment with hesitation and humility. I am an American, not English, and cannot claim the detailed knowledge and cultural sensibility that would lead to the best advice. But I was given a chance to recruit a wonderful group of people as the Advisory Group – most of whom have direct experience of your NHS while the rest admire it from afar – and who worked hard together to understand the problems and craft good suggestions. These included scholars whose careers have been devoted to studying safety and the conditions for excellence, clinicians and managers who know the NHS well, and, most important, patient representatives who could draw on their own experiences and their families', some tragic and hopefully never-to-be-repeated. This group gave me confidence that we would stay on the right track.

Of course, as you know, one of the main motivations for this assignment was the notorious "Mid Staffordshire" tragedy, in which serious problems in a hospital developed that led to avoidable patient deaths and injuries. That event spawned over two years of inquiry by Robert Francis, and, in early, 2013, the "Francis Report," with over 1700 pages and 290 recommendations. Your Government and NHS leaders turned to our Advisory Group for ideas on how to accelerate improvement of care in the wake of Mid Staffs. Ours was not the only group at all; lots of teams and leaders were tackling the same concerns while we did our work.

Our full report is now here for you and anyone else to see. It contains some technical material regarding regulation, improvement science, and management, but I hope that lay readers will find it comprehensible and sensible. Toward that end, I would like to share a few personal reflections for you possibly to ponder, as follows:

You will have read much in the public press that may alarm you about the patient care in the English NHS. After all, things did go quite wrong at Mid Staffs, and, like others, we believe that problems in care often occur throughout the NHS. In that, however, I assure you that the same can be said of every health care system in the world. Health care is complicated, and, even when the staff and clinicians are doing their very best (which is most of the time), errors occur and problems arise for patients that no one intends.

What you do have in the NHS is something that most other nations in the world don't have: a unified system of care that is completely capable of identifying its problems, admitting them, and acting to correct them. That is the process now underway; that is the process that led your leaders to convene our Advisory Group; and that is the process that can and, I believe, will help the English NHS to emerge over time as one of the safest health care systems in the world.

That is not easy. And it gets even harder if the staff of the NHS experience a culture of fear, blame, recrimination, and demoralization. I hope that you resist such general negativity, in yourself and anyone else, and instead clearly point the way with energy and optimism toward the care that you and I want, and that the vast majority of people who work in the NHS want to offer.

In the Mid Staffs story and elsewhere, there are occasional cases of people who willfully or recklessly did some harm. That, of course, cannot be tolerated, and occasionally strong measures of enforcement are needed. There are also clearly occasional organizations for which early warning signals suggest that serious problems may exist. In such cases, your government and NHS leaders can and should promptly investigate, reach conclusions, and act.

But enforcement, even though needed, is not really the route to an overall ever better NHS – the NHS you want. Instead, our report says, bet on “learning.” The English NHS is capable of vast and continual improvement of safety, quality, patient-centeredness, and even cost, if, and maybe only if, everyone involved engages in learning every day. The questions that come up in such a culture are ones like this:

- Whom do we serve, and what do they really want and need?
- How are we doing at meeting those needs?
- How do we know?
- What could we do differently that would do that better?
- Who knows something – a better model, maybe – that we could put to work here?

Imagine an NHS where everyone, all the time, was part of that journey, and has the respect and tools to improve. That’s what our Group recommends, in part, as you will see in this report.

We are recommending four main principles to guide everyone in trying to build an even better “learning NHS.” Here they are:

- Place the quality and safety of patient care above all other aims for the NHS. (This, by the way, is your safest and best route to lower cost.)
- Engage, empower, and hear patients and carers throughout the entire system, and at all times
- Foster wholeheartedly the growth and development of all staff, especially with regard to their ability and opportunity to improve the processes within which they work.
- Insist upon, and model in your own work, thorough and unequivocal transparency, in the service of accountability, trust, and the growth of knowledge.

In all of that you – patients, carers, and citizens – have a vital and exciting role to play. Your voice is key to the future. I hope that this report will give you more confidence in speaking up everywhere and all the time in a vital NHS, and will give those who care for you and want to help you the confidence and skills to invite you, hear you, and welcome you into authentic partnership.

Don Berwick