Speech: Getting the right leadership is vital for patient safety

“Trust me, I’m a doctor.” A phrase so reassuring that it’s a punchline.

We trust doctors and nurses more than any other profession. It’s a bond of trust that is both implicit and unspoken. You see us at our weakest, our most vulnerable. You hold our lives, and the lives of our loved ones, in your hands.

I was reminded of this unspoken bond of trust last week on a visit to The Princess Alexandra Hospital in Harlow. I met a mother with her newborn. Everything had gone well with the delivery and she was looking forward to taking her healthy baby home.

The visible joy, and relief, in her face is something every parent has felt. I’ve felt it myself with all 3 of my children.

We trust nurses and doctors, we trust the NHS, with something more precious to us than life itself. You have saved the lives of people I love.

We trust you because we know that you’ll do everything you can to help us. That you won’t give up on us. That the safety and life of my child is as important to you as it is to me.

But we can’t take that trust for granted. It has to be earned, and it must be protected. I think that’s why, when that trust is forsaken, the shock is so profound. When I learned what happened at Gosport, I was shocked.

Families had entrusted their loved ones into the care of doctors and nurses. Elderly relatives, at their most vulnerable and frail, were failed by a system that took that trust for granted. Think about your grandmother, your grandfather: how would you feel if the people you trusted most had let you down?

I get it. I understand. As Health Secretary, I’m sorry to those families in Gosport, Liverpool Community Hospital, Mid Staffs and everyone else who has been let down. But I’m not here today to point fingers and blame people.

Instead, we must learn the right lessons about creating a caring, compassionate culture, about protecting and renewing the bond of trust between the public and the NHS – our nation’s most loved and respected institution.

Because the other thing I was reminded of last week is that leaders create the culture. Because after I spoke to that new mother I spoke with the Chief Exec, Lance McCarthy, and I asked him what they do when things go wrong. What’s his approach to mistakes?

And he gave me a brilliant answer. He said: “If we’ve made a mistake, then

we've made a mistake. We should be open and honest, and apologise. And not be afraid to apologise because of any potential legal action."

As Secretary of State, that's exactly what I want to hear. Because we all make mistakes. We should strive to avoid them, of course, but the fact of a mistake isn't the biggest problem. It's how we respond to them and how we learn from them, that's what's most important. And we must never let our fear of the consequences, stop us from doing the right thing.

So what Lance has done at his Trust is introduce a 'behaviour charter'. Patients, their families and medical colleagues know what they can expect: openness, honesty, trustworthiness.

That way when mistakes do happen there's an honest conversation: this is what went wrong, we're sorry, this is what we're doing to fix it.

It's not an admission of liability. It's an acknowledgement that we can do better. It's often the first step towards acceptance for the patient and their family. And it's a vital part of the process of continuous improvement we need to see everywhere in the NHS. Taking responsibility, learning the lessons that need to be learned, continuous improvement.

And what Lance has found is that clinical negligence claims haven't gone up at his trust since they introduced this new charter. In fact, Lance believes, when people feel like they've been treated with honesty and candour, they're less likely to resort to legal action.

The simple act of saying sorry maintains the bond of trust with the public even when things don't go as planned. But this isn't just a moral issue for the NHS – as important as that is – it's a financial issue as well.

Compensation pay-outs have quadrupled from half a billion to £2 billion pounds a year over the past decade. That is unacceptable and it's clearly unsustainable.

If we don't do something about the growing number, and value, of clinical negligence claims, it threatens to swallow up the record £20.5 billion a year we're putting into the NHS, and derail our Long Term Plan to transform the health service.

And that infuriates me, because it's an injustice for taxpayers and our hardworking NHS staff. This is a once in a generation opportunity to put our health service on a forward footing so we can look to the future with confidence.

We can't afford to let it go to waste. There is a moral and financial urgency to act. We must improve patient safety, so there's:

- less paperwork for medical staff and more time for patients
- faster resolution for those who are wronged
- more money for frontline NHS services and less taxpayers' money going to lawyers

That’s what I want to see. That’s the approach we’ll be taking in our new patient safety strategy.

Creating a more just culture in the NHS, a more open, honest and trustworthy culture, starts at the top. Getting the right leadership is vital. We need more people with clinical backgrounds and more people from outside the NHS.

We need to ensure they get the right support, training and development so they can lead their organisations effectively and create the right culture for staff and patients.

How do we strengthen this leadership? How do we encourage more inspirational leaders into the NHS? And how do we ensure we can hold to account that leadership once in place?

First, and perhaps counter intuitively, I think we must cut the turnover rate at the top. To improve leadership in the NHS we must fire fewer people and attract the best talent. NHS leaders have some of the toughest – yet most rewarding – jobs in the country. So let’s support them to do the job they need to do – and that will encourage more to step up.

Next, we need to have a better structure, both to support and hold to account. Today we’re publishing Tom Kark’s review into how we can improve NHS leadership. I’d like to thank Tom for his work on this and I welcome his recommendations.

Kark recommends that all directors must meet minimum competency standards to sit on the board of any health organisation, and where training is needed to meet those new standards, then it should be made available

He also recommends a central directors’ database where information about qualifications and employment history can be easily accessed

These new recommendations will ensure the fit and proper persons test is met and that unqualified or unsuitable staff can’t just move somewhere else in the NHS. We accept these recommendations in full and will get on with implementing them immediately.

I’ve asked Dido Harding to consider the further recommendations, and how we can implement these recommendations, throughout the health service.

Third, we’re working with the Healthcare Safety Investigation Branch and NHS Improvement to give more support to families when things go wrong.

A new family engagement model will ensure relatives play an integral part in any investigation, that their concerns, and their complaints, are listened to and acted on.

Nobody should feel like they’re being fobbed off or a nuisance. We must give families all the information in an open and transparent way. And ensure they’re treated with sensitivity and compassion before, during and after any investigation.

That’s the same approach we’ll be taking when independent medical examiners start being introduced across England from April. Every death will be scrutinised by either a coroner or a medical examiner.

Medical examiners will be someone bereaved families can talk to about their concerns. They will ensure investigations take place when necessary, help detect and deter criminal activity, and promote good practice.

This new system will be overseen by a new independent National Medical Examiner. And training will take place to ensure a consistency of approach and a record of scrutiny.

Finally, we need to encourage whistleblowing. Despite our best efforts, mistakes happen. We’re all human, we’re all fallible. Any doctor who says they’ve never made an error isn’t telling the truth. And the truth is more important than any one error.

Mistakes should be seen as an opportunity to learn and improve, not a need for cover-up and denial. Honest feedback is a gift.

So whistleblowers are doing the NHS a great service. Someone, who has the courage to speak up and put their head above the parapet, should be encouraged and embraced. Yet, sadly, all too often, they’re ignored, bullied and worse: forced out.

Making someone choose between the job they love and speaking the truth to keep patients safe, is morally abhorrent and operationally foolish. It’s an injustice I am determined to end.

We must change the way the system views whistleblowers: from a problem, to part of the solution. We must embed a ‘learn not blame’ culture in every part of the NHS, and ensure there are protections for staff and the public who speak up to save lives.

So we must get the right leaders to create the right culture. A just culture, an open, honest and trustworthy culture. A culture of learn not blame. Saying sorry when we get it wrong, earning the public’s trust, never taking it for granted. Encouraging and supporting people with the bravery to speak up.

There’s no one solution to patient safety. It’s a series of steps. It’s a path of continuous learning and improvement. There will always be more we can do, and we must always keep striving to do better.

I want Britain to be the best country in the world to be born. That begins with making the NHS the best – and safest – place in the world to give birth. I want every parent to experience the same joy the mother of that newborn did, thanks to our brilliant NHS. Thanks to our brilliant NHS staff.

So let us renew that bond of trust with the public. Make it a public, spoken, bond of trust: we will always be open with you, we will always be honest with you.

When things go right and when things go wrong, you can always trust the NHS

to be there for you and your family.