

Guest Editorial

Patient safety: the journey towards safer radiotherapy

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The report by Robert Francis¹ into events at Mid Staffordshire Hospitals has ensured that patient safety is and should remain the number one priority for the National Health Service (NHS). Although the focus of the report relates to failings in care on wards, involving mainly nurses and doctors, there are also many lessons for radiotherapy services in terms of the effects of poor leadership, inadequate staffing levels, and an immature safety culture on keeping patients free from harm and ensuring they receive compassionate care.

Radiotherapy was highlighted as a risk in the Chief Medical Officers report of 2006 and this led to the publication of *Towards Safer Radiotherapy*. In the same year the World Health Organisation² also published a *Radiotherapy Risk Profile* that highlighted the highest risk areas of the pathway and suggested interventions to improve safety, including checklists, reporting and learning from errors and adequate staffing.

*Towards Safer Radiotherapy*³ made some very bold recommendations: development of a safety culture where staff are encouraged to question, report incidents and raise concerns, and where the Chief Executive has responsibility in ensuring such a culture. Staffing levels and skill mix should be appropriate to the numbers of patients being treated, and the environment should be designed to reduce interruptions. The importance of clear communication was also highlighted. What is interesting is that many of these same recommendations have been repeated since 2008

in a variety of patient safety policy documents and most recently in Francis¹ and the reports that followed including the Governments' response to Francis—Department of Health 2014 *Hard Truths—The journey to putting patients' first*.

In the United States there has also been a drive to make radiotherapy safer. The American Society for Radiation Oncology (ASTRO)⁴ published—*Safety is No Accident*. The report recognises radiotherapy is increasingly complex and sets out the requirements for radiation oncology departments to deliver safe care. It also mentions the importance of adequate staffing and focuses on designing out errors with human factors engineering, to design workspaces that minimise interruptions, noise and clutter. In the United Kingdom there has been increased focus on communication and design of the environment to reduce interruptions in promotion of human factors.⁵ Human factors are described by Catchpole⁶ as:

Enhancing clinical performance through an understanding of the effects of teamwork, tasks, equipment, workspace, culture and organisation on human behaviour and abilities and application of that knowledge in clinical settings.

ASTRO also recommends safety briefings at the beginning of shifts and safety rounds or executive/leadership walkrounds. This is where the leaders of an organisation carry out informal visits to wards/departments to talk to staff about any challenges they are facing in keeping patients safe.

A lot of work has been done in radiotherapy in recent years to improve incident reporting. Public Health England produce a monthly newsletter

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called Safer Radiotherapy, which includes analysis of radiotherapy errors reported to the National Reporting and Learning Service, the aim being to disseminate learning. Reporting of radiotherapy errors has steadily increased since 2010 from 294 incidents in a quarter to over 1,500 in 2013.⁷ The overwhelming majority of reported incidents (96.9%) are minor incidents or near misses. A report from the Health Protection Agency⁸ analysing radiotherapy errors shows that there has been a reduction in the number of higher level errors and an increase in the number of lower level errors. This is very encouraging suggesting a maturing patient safety culture, and is exactly the direction of travel called for by the Department of Health⁹ in the National Outcomes Framework where patient safety is one of the five domains being focused on. The national outcomes framework target is an increase in overall reporting of safety incidents, alongside a decrease in the number of incidents resulting in severe harm and death.

Robert Francis called for fundamental culture change in the NHS. The positive signs of increased incident reporting in radiotherapy suggests that the journey towards a more transparent culture of learning is underway in radiotherapy departments in England and Wales. However, the continued reports outside of radiotherapy of hospitals trying to hide the truth or staff feeling unable to raise concerns tell us that across the NHS in general there is still a long way to go. The progress in radiotherapy in relation to reporting and learning from errors should be used as an example within organisations for other departments to learn from.

Although progress is being made towards safer radiotherapy, we must avoid becoming complacent and we must ensure that the next generation of radiotherapists are trained in patient safety from the beginning. In his 2013 report,¹⁰ Don Berwick highlights the importance of patient safety education for all health professionals:

'Mastery of quality and patient safety sciences and practices should be part of initial preparation and lifelong education of all health care professionals'.

A recent concordant from the National Quality Board¹¹ talks about the importance of including human factors into core education curricula. There are already some good resources to support

radiotherapy lecturers in teaching patient safety and human factors such as the World Health Organisation¹² multiprofessional patient safety curriculum and the Institute for Healthcare Improvement¹³ free online patient safety/human factors courses for students. There is also a growing movement of student-led patient safety chapters that supplement formal patient safety teaching and support interprofessional learning.

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