Deaths from NHS blunders up 60%

Care 'is suffering as staff chase targets'

Botched: Errors during surgery accounted for nearly 400 deaths

By **Daniel Martin**
Health Reporter

THE number of patients killed by hospital blunders has soared by 60 per cent in just two years, the Daily Mail can reveal.

Official records show that 1,048 died as a result of outbreaks of infections, botched operations and other mistakes in 2007/08. That was up from 2,273 two years before.

Critics say quality of NHS care has suffered as doctors and nurses come under pressure to meet Government waiting time targets. The sharp rise is also down to the fact that more trusts have started to record medical errors – revealing a death toll which in previous years remained hidden under the carpet.

But experts say the true toll is almost certain to be even higher, because many hospitals still do not record all of the patient safety incidents – meaning that lessons which could have been learned are lost.

In October last year, the Patients Association warned that one in every 300 NHS patients were killed because of medical blunder.

The latest figures, uncovered by the Healthcare Commission, show that 365 died last year due to botched operations and 136 because scans were read wrongly or patients incorrectly diagnosed.

Some 360 died from infection contracted in hospital – including superbugs and 14 due to problems with documentation and records.

Another 34 were killed by wrongly-administered drugs and 40 by faulty medical equipment. There were 173 cases of deaths following simple accidents, usually falls.

On top of this, 22 died as the result of abuse by hospital staff or visitors, and 115 died because they were not treated properly between wards or hospitals. Another 87 killed themselves on hospital premises when their depression should have been spotted by doctors.

A further 42 other blunders brought the total toll to 1,048.

The figures are certain to rise as hospitals get round to reporting mistakes which took place between April 2007 and March 2008 to the National Patient Safety Agency.

'These statistics are stark and the trend is shocking,' said Lib Dem health spokesman Norman Lamb. 'There needs to be a change of culture at the heart of the NHS. We have got far too many targets and there is a real risk that, although they are very effective at addressing a specific issue, they seem to take do not see safety as a priority.'

Roger Gean of pressure group Patient Concern said: 'There is no shocking. Patients are already extremely nervous when they have to go to hospital, so they need this news like a hole in the head.'

Lucy Watts of pressure group Action Against Medical Accidents, said many incidents are not reported to official bodies, so the figures. He added: 'We need to make patient safety a much higher priority for doctors in training and there needs to be an overhaul of surgical practice, where already avoidable errors happen.

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Resources and staffing are also an issue. It is no surprise to find that more things go wrong at weekends and at night.

Concerns around the safety of many surgical operations carried out on the NHS are so serious that the all-party Commons health select committee is looking into the issue and will report in April.

Clare Brown, whose five-year old daughter Bethany died as a result of mistakes made during routine surgery in 2006, said: 'I have no doubt these figures will continue to rise unless hospital trusts, and surgeons in particular, are prepared to learn from their mistakes.'

Miss Brown, whose story is told in today's Good Health section, added: 'Nobody should be afraid to go into hospital.

But equally, no one should be afraid of asking questions that will make the doctors in charge of their care think carefully about how they behave.

The rise in avoidable deaths mirrors recent rises in NHS pay-out for blunders. Around 6,000 cases go to court each year and compensation for injured patients rose by 18 per cent last year to £822m.£bn.

A spokesman for the Department of Health said: 'The NHS sees a million people every 36 hours. Unfortunately, as in any health service around the world, sometimes mistakes will occasionally happen.

'Only a tiny number of errors put patients at a greater risk and the quality and safety of healthcare is improving all the time.'

For diabetes

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