NHSSB CONFERENCE ON PATIENT SAFETY

Doctors are taught the principle laid down by Hippocrates: "First, do no harm". This is self-evidently a sound instruction and I am sure that we would all subscribe to it. In many ways, however, it is a counsel of perfection. The reality is that we live and work in a risk-laden environment where the objective of doing no harm is neither the reality nor something which can easily be delivered.

When we consider the conditions which have to be treated, the circumstances in which that treatment often has to be delivered, and, equally, the often imperfect state of our knowledge, skills and equipment – to say nothing of the unknown variables which can enter the equation – it is clear that the odds are stacked against us delivering perfect outcomes every time. Judgements have to be formed, assumptions made and action taken which is often as much an informed guess as it is a scientifically validated response.

We therefore cannot guarantee patient safety in absolute terms. But this does not mean that we must accept the inevitability of poor outcomes. The task for us is to be

alert to the risks and to take action which is both appropriate and effective.

The reality of course is that adverse incidents occur every day. Research shows that the rate of adverse incidents among hospital patients ranges between 4% in an American study to 16.6% in an Australian study. The average is of the order of 10% and this has been found to be the case in countries as far apart as Canada and New Zealand. It is also true of the UK, where some 10% of patients admitted to NHS hospitals have experienced an adverse incident.

Moreover, it is estimated that roughly half of these could have been prevented and it is salutary to note that 8%, or 1 in 12, may actually have been a contributory factor in the death of the patient. Indeed, in a report by the US Institute of Medicine in 1999, it was estimated that more people die each year from adverse events in the delivery of healthcare than die from car accidents and injuries in the workplace combined.

This concern over the risk to the wellbeing of patients is also reflected in the increased awareness of the importance of patient safety here in the UK following

serious cases such as the deaths of children following heart surgery at Bristol Royal Infirmary, the practices of Dr Harold Shipman, and the accidental lethal injection into the spine of a 16 year old boy in Nottingham. These well-reported events have all pointed up the fallibility of doctors and the risks to patient safety in the health care setting.

Nor is this confined to the health care arena – cases within the community have also pointed up failures in social care and we are all aware of such high profile cases as the Victoria Climbié case and, here in Northern Ireland, the case of the Romanian twins. As a result of these cases, there is a much sharper appreciation amongst the population that action needs to be taken to protect patient safety and to have health and social care professionals take greater responsibility for their actions.

Most health and social care is delivered safely and effectively. The vast majority of health and social care professionals are keen to provide safe and effective treatment to their patients. But yet, undeniably, things do go wrong from time to time. Our task is to ensure that we understand the reasons why this happens and to do all we can to minimise it.

We also need to be aware that, in addition to the impact in terms of the harm to patients from these adverse incidents, there is also a significant economic impact. It is estimated that the additional costs of hospitalisation, clinical negligence claims and hospital acquired infections in the UK cost the NHS over £3 billion every year. And there is also an unquantifiable cost in terms of the erosion of the public's trust and confidence in us. So, it is in all our interests that we should take sensible steps to improve our record on patient safety.

And of course this approach is not unique to Northern Ireland. Many countries in the world have been focusing on the issues of adverse incident reporting and patient safety; and we can safely say that patient safety is currently a global priority. Last October, the World Health Organisation launched the World Alliance for Patient Safety in recognition of the fact that the ever-increasing incidence of adverse events in health care across the world has led to the emergence of an international drive to create a "Culture of Safety". WHO sees itself as taking the lead in building global norms and supporting the efforts of countries in developing patient safety policies and practice.

Sir Liam Donaldson, the CMO in England, is the Chair of the WHO Alliance and he has already stated that the goal of the Alliance will be nothing less than to save lives, to reduce the risks to patients and to ensure that lessons will be learned across the world as each country works to find its own solutions to this problem.

So our emphasis on patient safety is both timely and part of a world-wide initiative. The obligation on all of us is to create the right atmosphere – to strive for the culture of safety that WHO has espoused. In doing so, lessons will be learned and universal safe practices will be identified which will benefit us all.

So how do we deliver on improved patient safety? Well, what is clear is that we need to avoid two common errors in our approach. One is the tendency to bring the spotlight of blame to bear on those involved. Such an approach makes it difficult for people to admit errors and is certainly not conducive to the sort of atmosphere we need for learning lessons.

The other approach is that of what we might describe as the error-free work ethic. It works on the basis that if only we all concentrated better and worked harder we would be

able to eliminate errors. In saying this, I am reminded of the experience of a British company which ordered high specification component parts from a Japanese company. In the contract it stipulated that the parts had to be of high quality, with no more than 3% defective. When the parts arrived, there was a separate box and a covering letter which said our products are always 100% error free and so this box contains the specially manufactured defective parts you ordered.

As the growing volume of evidence shows, this analogy from manufacturing industry is never going to be the case in our world. Health care will always involve risks and the problems are often more to do with the systems, processes and working practices than with the degree of application or concentration level of the individuals.

Clearly, we need to tackle these issues in a concerted way. For a start, we need to get rid of the blame culture. We should be aiming for an open and fair culture in which mistakes are matters from which lessons are learned and staff feel able - and indeed are encouraged – to inform others that things have gone wrong and to work with others to identify what the root causes were and how they

might be corrected for the future. It is only in this way that we can properly address the issues of patient safety.

There are clearly a number of dimensions to this. One has to be to build the skills and confidence of everyone involved in handling patients. Training and continuing professional development are obviously important in ensuring that skills are continually honed and knowledge and competence are kept up to date.

The issues of appraisal and the monitoring of the performance and competence of individuals have a particular significance. We cannot take it for granted that people will retain their skills, or indeed their motivation, and our system must have the capacity to appraise, assess and assist those whose performance is starting to slip.

While we need to ensure that health and social care staff are fully skilled and well-trained, we also have to be aware that the evidence which is accumulating across the world is pointing increasingly at the systems issues in adverse incidents. Although the tendency in the past has been to focus on the mistakes made by individuals, the research on safety in healthcare and other areas of life has shown

that even the best people sometimes make the worst mistakes and that errors tend to form recurrent patterns regardless of the people involved.

This means that we must always look at our systems and ask ourselves how the incident could have been prevented. This change of focus from the failings of individuals to the operation of the system is both more supportive of our staff and more likely to lead to lasting improvements in patient safety.

To achieve this, we have to have effective reporting mechanisms in place. We cannot hope to keep our standards high if we do not have the basic information on which to reassure ourselves that we know what is going on. American studies have found that as medical reporting systems improve, the error detection rates increase and the severity of the errors themselves eventually decrease.

Information technology can help us here and we will need to make some investment in the development of health information systems to support the drive for improved patient safety. However, the key is that proper analysis of the information is needed if we are to learn from it. It is therefore important that we analyse the root causes of

medical errors so that we can properly identify what went wrong and how the system failed. This is very much an evidence-based approach and it should both give credibility to the lessons we want to disseminate and deliver lasting improvements in the safe operation of our systems.

A final point I want to make on patient safety is the importance of communication with the patient. In any adverse patient event there is an individual or group of relatives who need to be informed of what has happened. If we are to be caring and responsible in our handling of patients, this is something which we neglect at our peril.

We have to acknowledge that something has gone wrong and that harm has happened to an innocent party who has placed their trust in us to protect their wellbeing. At the very least, an apology is merited and at its most basic there is a need to be open and honest in explaining the problem. This openness is obviously dependent on our staff being prepared to speak out honestly. Again, the creation of a blame-free environment is the critical aspect of this and for both our staff and the patients and their families the focus must be on our willingness to identify the flaws in the system, which can and will be put right,

rather than on pinning the blame on the failings of particular individuals.

It is instructive to note that this is what patients want. A recent study commissioned by the Department of Health in England found that almost 60% of people wanted the NHS to react after a patient safety incident by offering an apology or explanation and undertaking an enquiry into the causes. Only 11% wanted financial compensation and less than 6% wanted disciplinary action taken.

So the responsibility lies with us. We can either close ranks and refuse to admit anything or we can be open and honest. If we take the latter route, we will need to support our staff and we will need to take some bold decisions. But the advantages are clear. We can create a learning culture in which errors will be reduced; we will build a better, and more honest, relationship with both our staff and our patients; and we will help to ease the trauma suffered by those who find themselves on the receiving end of an adverse patient event. But most of all, we will make our hospitals and our social care facilities safer places for the patients who submit themselves to our tender mercies.

Thank you.

294