



Patient Safety

The MDU's response

September 2008

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MEMORANDUM ON PATIENT SAFETY

Submitted on behalf of the Medical Defence Union

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Executive summary:

- 1 We do not have much to add to the evidence we have put before the committee in 1999 on adverse clinical incidents, other than to point out that our two recommendations in this document are also recommendations that were made in 1999 but have not, so far, been addressed. They are:
 - 1 We recommend that members of the secondary and primary care teams take part in regular systematic significant event audit and that the results are collated regionally and on a national basis, to identify potential risks to patient safety. Such information can be shared with managers and clinicians to assist them to improve patient safety.
 - 2 We recommend that complaints and claims data is pooled across the UK. Details of the complaints and claims analysed and risk management advice should be shared regularly with managers and clinicians to assist them to make decisions and to inform their practice.

MDU Submission

Established in 1885 the Medical Defence Union (MDU) is the UK's leading provider of medico-legal services to our members who are over half the UK's doctors in hospital and general practice, and over a third of the UK's dentists. We provide indemnity insurance for members' professional negligence claims arising out of their treatment of patients in the primary care and independent sectors. We also provide members with a wide range of advisory services which can include a 24-hour telephone medico and dento-legal advisory service;

advice and assistance with the NHS complaints procedure; disciplinary investigations by their employer/contracting body and the General Medical and Dental Councils, and other procedures such as inquests and criminal investigations arising from clinical care. We also provide members and NHS bodies, such as the National Patient Safety Agency, with analyses of cases from our files, and risk management advice to allow them to consider the lessons learned in their own practices, with the aim of minimising future incidents and improving the quality of patient care.

To give an idea of the extent of the assistance provided to members; during 2007 we received and answered 25,000 phone calls from members through the 24-hour freephone advisory service, and opened over 10,000 files new files on claims, complaints and other advisory matters. Our comments are informed by our experience of assisting clinicians in the NHS and independent sectors. We do not have much to add to the evidence we have put before the committee in 1999 on adverse clinical incidents, other than to point out that our two recommendations in this document are also recommendations that were made in 1999 but have not, so far, been addressed. They are:

We recommend that members of the secondary and primary care teams take part in regular systematic significant event audit and that the results are collated regionally and on a national basis, to identify potential risks to patient safety. Such information can be shared with managers and clinicians to assist them to improve patient safety.

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What are the risks to patient safety and to what extent are they avoidable?

It has been suggested, for example by the Chief Medical Officer (*Good Doctors, Safer Patients*, July 2006) that the NHS can learn from the airline industry in terms of patient safety. While we agree that helpful parallels can be drawn, different considerations often apply in respect of treatment of patients and patient safety. With an aircraft, if systems fail, or if there are not sufficient or adequately trained crew, or if there is a fault with the plane, the pilot can decide not to take

off until the matter is resolved or, in extreme circumstances, to abort that flight. Doctors are working in quite different conditions and, even if the circumstances are not ideal for treatment of patients, it may not be possible to postpone treatment because the patient's condition requires immediate action. Acting in patients' best interests, doctors sometimes have to treat patients in conditions that are less than ideal because there is no other option.

Clinical practice cannot be risk free. Even if it were possible to screen out known and possibly preventable risks such as practitioner, equipment, systems or procedural error, the very nature of clinical treatment means that it may be imperative to treat a patient in less than ideal circumstances, knowing there is a risk to patient safety, because not to treat would leave the patient open to more risk.

However, we believe there are some steps that can and should be taken to minimise risks and to improve patient safety, principally in respect of improving the information collected, analysed and made available to managers and clinicians so they can use it to improve decision-making and care of patients.

To understand fully the role that human error and poor clinical judgement, as well as systems, procedures, equipment and other failures play in harm to patients, it is first necessary to ensure there is sufficient data available to identify and analyse these risks. Managers and clinicians in the NHS need access to factual, objective and quantitative data that they can use to inform their management decisions and practice. The MDU understands that such data is not provided systematically throughout the NHS and we believe, for example, that information in respect of clinical audit, significant event analysis and risk management should play a much greater role in patient safety.

Clinical staff should be auditing their outcomes on a regular basis as part of a quality approach to practice. In addition, data gathered as a result of patient safety incident reporting systems should be used to highlight areas of practice that may need clinical audit. In the MDU's experience many adverse clinical incidents arise because of systems and equipment failures which are not the responsibility of the individual member of the healthcare team, but rather the result of managerial decisions taken, sometimes years, earlier. It is essential that senior managers, and not just those with clinical responsibilities, are fully

involved in receiving and acting upon information received from audit and patient safety incident reports. The data should be used to identify high risk areas of practice and will help to avoid harm to patients, and to learn from errors so that avoidable mishaps can be avoided.

The MDU has focused on patient safety for many years and has provided members with information about key medico-legal pitfalls so that they can consider whether lessons learned from a wide range of cases are applicable to their own practice. Our extensive database of cases involving patient safety incidents, claims and complaints, principally but not exclusively in primary care, provides us with a broad view of the issues underlying patient safety incidents. Analyses of our database form the basis of our risk management advice to members in various clinical specialties. Data is aggregated and anonymised to protect patient and doctor confidentiality. Understanding common issues leading to adverse events, and introducing measures to prevent a recurrence is a positive contribution to patient safety. The MDU has developed risk management tools for our GP members to use to assess the clinical risks in their own practice. We encourage members to inform patients that they have such a system in place, as it is a clear indication of their concern for the quality of health care they provide.

For example, the MDU's files show that the key factors that can lead to adverse clinical incidents causing harm to patients include:

- Faulty technique/procedure
- Communication failure
- Inadequate medical records
- Systems/administration/organisational failures
- Failures in the doctor's clinical judgement
- Lack of training
- Others - including problems with staffing, continuity of care and equipment failure

It would not be possible to quantify whether this risk management activity has had an effect in the reduction of complaints or claims as there are too many variables; but we believe it is important to share information from our database with members and the profession more widely, in their interests and that of their

patients.

We point out, however, that such information as is collected in NHS practice is incomplete. Patient safety incidents and outcomes should be investigated through systematic audit and mandatory patient safety incident reporting systems, and this should not be dependent upon complaints or claims from patients and others. Standardisation of audit and adverse incident reporting systems would allow comparisons to be made of their effectiveness on an NHS-wide basis. We recommend that clinical staff and managers regularly receive feedback of the effectiveness of such systems so that they can evaluate their own performance

In addition we believe that a collaborative data pooling exercise is essential across the UK if the Department of Health wishes to identify and to reduce the potential for incidents which give rise to complaints and claims. We are happy to offer our anonymised data for analysis together with NHS data and for dissemination to clinicians and managers.

A copy of our July 1999 submission on 'Procedures related to adverse clinical incidents and outcomes in medical care' have been provided separately.