MEMORANDUM OF EVIDENCE TO THE HEALTH SELECT COMMITTEE INQUIRY INTO PATIENT SAFETY

1 Executive Summary

This memorandum sets out the views of the charity Action against Medical Accidents (AvMA) in respect of the terms of reference the Committee has set for its inquiry into Patient Safety. In particular I would draw the Committee's attention to our comments regarding:

- urgent action to implement recommendation 12 of Safety First and 'Being Open' a reality (see paragraph 4.4),

- consolidation of the National Patient Safety Agency (NPSA) as the key central organisation formed purely on patient safety, and more 'clout' to be given to its alerts/ guidance,

- more priority/resources being deployed to safety 'solution' or intervention work on known issues rather than making reporting systems more elaborate,

- action to be taken to increase reporting rates in primary care – perhaps by making reporting compulsory,

- development of the 'avoidability test' as an alternative test to the 'Bolam test' to make the NHS Redress Scheme fairer and more aligned with patient safety objectives and culture,

- review of the NHS Litigation Authority and transfer of its responsibility for standards to a more appropriate body.

2 About Action against Medical Accidents

Action against Medical Accidents (AvMA) is the UK patients' charity which is specifically concerned with patient safety and with justice, in the widest sense, for people affected by medical accidents. Established for 25 years, AvMA was campaigning for better patient safety well before the issue was appreciated by Government and the NHS. AvMA has influenced the development of the patient safety movement in the UK and the establishment of agencies such as the National Patient Safety Agency and Healthcare Commission. AvMA's Chief Executive, Peter Walsh, is the only patient representative on the National Patient Safety Forum, chaired by Sir Liam Donaldson and Sir David Nicholson. AvMA provides advice and support to around 4,000 people a year who have been affected by medical accidents, which provides it with a unique insight to what goes wrong and the experience of patients and families following a medical accident (or "adverse event"). AvMA also works closely with other patients' organisations and is a partner of the National Patient Safety Agency (NPSA) in managing the Patients for Patient Safety Project. This project implements recommendation 13 of Safety First by establishing a national network of patient safety champions. AvMA draws on all of its experience and contacts in providing these comments.

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

3.1 AvMA believes that too much emphasis is put on individual human error and poor clinical judgement as opposed to systems failures. That is not to say that human errors should not be identified or that they are acceptable, but rather that there should be systems in place to reduce the risk of such errors. Organisations should take corporate

responsibility for patient safety. When things go wrong, investigations should seek to identify the root causes and missed opportunities for intervention or prevention rather than simply identify individuals who are "to blame" for the incident. However, this should not be at the expense of personal accountability where appropriate. This represents a significant need to change the culture in healthcare. The development of phraseology such as "blame free" or "no blame" culture as the desired "patient safety culture" was unfortunate and unhelpful as it was taken by some to condone a lack of personal accountability. We support the concept of a "patient safety culture" being a "fair blame" and "open and fair culture".

3.2 Unfortunately, a number of factors mitigate against the development of a genuine patient safety culture. One which we would like to highlight, and which features prominently in any discussions with health professionals about patient safety and incident reporting, is that of litigation. There is currently a reliance on civil litigation being the only means by which patients or families affected by clinical negligence can obtain the compensation they need and deserve. The definition of negligence used by the civil courts means that the focus of attention when something goes wrong is almost always centred on finding an individual who is "to blame" (where personal negligence led to the harm caused). This is unhelpful. However, in the absence of a credible alternative means of offering fair compensation, it would be entirely wrong to seek to restrict injured patients'/families' access to justice through this route.

3.3 The Chief Medical Officer called for a radical reform of how compensation is provided for clinical negligence in his report Making Amends. Whilst some of his recommendations have been reported by the Government, the proposal for an NHS Redress Scheme was taken forward by the NHS Redress Act 2006. This provides the legislation framework for establishing an NHS compensation scheme for clinical negligence cases which would avoid the necessity to take legal action for some claimants. However, the legislation restricts the scheme to cases which would be eligible for compensation in tort, i.e. to use the civil courts' definition of negligence. We believe that this is a fundamental flaw and a missed opportunity to rise to the challenge posed by the Chief Medical Officer and to find a compensation system which is both fair and conducive to a patient safety culture.

3.4 We believe that the concept of "avoidability" should be central to work on patient safety and also offers a suitable way forward with regard to clinical negligence compensation. We recommend that any NHS Redress Scheme should replace the legal definition of negligence (the 'Bolam test') with what we denote as an "avoidability test".

AvMA propose that what we have called an "avoidability test" is applied to determine eligibility for redress. In essence, this would mean that in cases which are being considered under the Redress Scheme the first question to be asked would be *"Could the adverse outcome have been avoided if the organisation responsible for the treatment had followed accepted good practice?"*

If it could be demonstrated that good practice had been followed, there is no qualification for redress. If the practice is not considered to be good/in accordance with standards and guidelines in Wales, there would be a qualification for redress, unless the NHS body could demonstrate, on the balance of probabilities, that the adverse outcome was not caused by the failure to follow good practice.

We believe this approach has significant advantages. For example

- it moves away from the blame culture/focus on pinning blame on individual health professionals which is considered a hindrance to improving patient safety,

- it focuses on root causes and systems issues, meaning that one investigation should result in the answers needed to help improve patient safety as well as to whether or not someone deserves redress,

- it is fairer. Most people would agree that someone who has suffered harm as a result of sub-standard treatment should be entitled to redress.

- It would drive quality improvement by making the acceptable standards "good" practice rather than practice which is not so bad as to be categorised as "negligent".

3.5 We believe that society rightly places great priority on the prevention of avoidable harm in healthcare, i.e. "patient safety". We do not agree with the view expressed by some health economists that a purely quantative approach to assessing the priority attached to any patient safety intentions/solutions should be applied. Principles such as "fairness", "justice" and "public confidence" (and some would say, "common sense") must also be considered. Thus, whilst the prevention of a small number of perfectly avoidable deaths as a result of errors in administering intravenous injection of drugs is justifiable. For example, even if an assessment of quality adjusted life years (QALYs) against other potential uses of the resources would suggest that the alternative use was more productive. This is because we place higher priority on "moral weight" to addressing problems which we know are perfectly avoidable and the consequence of which are so serious. We therefore suggest that patient safety is a special case and continues to deserve more resources to be put towards it.

4 "<u>What the effectiveness is of the following in ensuring patient safety</u>"

4.1 <u>Local and Regional NHS Bodies etc</u>

We believe that NHS Boards and Primary Care practitioners in particular have a long way to go to establishing a patient safety culture. With regard to NHS Boards we would point to the apparent failure to take guidance such as Being Open seriously. With regard to primary care practitioners we would point to the scandalously low rates of reporting to the NHS national reporting and learning system.

4.2 We believe that the introduction of further public/private mix in provision of NHS healthcare has significant risks, and that the impact on patient safety should be taken more into account in making decisions in this regard. For example, we do not think that patient safety issues are examined carefully enough in the rush to establish independent sector treatment centres. We have seen some of the unfortunate consequences in our casework. It seems obvious to us that it is a huge enough challenge to develop a patient safety culture and consistent opportunities to patient safety in a large public institution such as the NHS. Frequenting the system and placing responsibility for provision in a variety of different private organisations whose primary motivation is profit can only make this more difficult.

4.3 We approve of Safety First as the template for improving patient safety and the sense of urgency which it sought to instil. This momentum must be continued until we see well evidenced and sustained improvements. We believe that significant achievements are being made in the implementation of Safety First recommendations. However, we would like to draw the Committee's attention to what we believe is more urgent and robust action to address the needs identified in recommendation 12.

4.4 Recommendation 12 of Safety First recognises that "Communicating openly and honestly with patients and their families when things go wrong is a vital part of patient safety" and recommends action to make this a reality. We welcome this, but regret the lack of action so far. The NPSA has already published excellent guidance, training and a safety alert on "Being Open". However, there appears to have been little take up of the training and, given the number of 'must do's' that NHS Boards are faced with, they are unlikely to make this guidance a priority. We think it is fundamentally wrong that something so vital should be relegated to optional guidance.

- The Chief Medical Officer's recommendation for a legal 'duty of candour' (Making Amends, 2003) is revisited.

- The Healthcare Commission/new Care Quality Commission actively monitor NHS bodies' implementation of the Being Open guidance/safety alert and uptake of the training.

- Resources are made available for NHS bodies to take up training on 'Being Open'.

- The principle of 'Being Open'/patients' and families' right to full and unfettered information and explanation of what may have gone wrong with treatment and what will be done to learn lessons, is enshrined in the NHS Constitution.

- The NHS Litigation Authority withdraws its circular on 'apologies and explanations' (August 2007) and replaces it with more enlightened guidance. (See Comments on NHS Litigation Authority below).

4.5 We believe that spending on patient safety could be used more effectively. We have always felt that it was a mistake to place so much emphasis on the development of an elaborate reporting system at the expense of actual intervention/solution work. There is ample evidence of the same sorts of errors being reported already without going to extreme lengths to identify new issues. We agree with having a reporting system, but would like to see a re-alignment of resources with priority being given to solution work. Some of the most useful work done by the NPSA for example has been on patient safety problems which have been known about for some time and have been crying out for action (e.g. Wrong Site Surgery; Hospital Acquired Infections). There are many more areas which are known about, which do not require the reporting system to be identified.

4.6 We recommend that Safety Alerts and other publications from the NPSA are given more 'clout'. The public find it quite incomprehensible that safety alerts may not be implemented by NHS bodies, with no comeback for them. If the NPSA is not itself to be given more authority, there must be a close marry-up with the new Care Quality Commission to ensure that safety alerts and guidance from the NPSA are implemented by NHS bodies and boards held to account if they are not.

4.7 We think it is a right that there is a body such as the NPSA which is solely concerned with patient safety, so as to give patient safety the prominence and priority it deserves. The NPSA should be strengthened and be given the confidence and stability it needs to fully develop its role. We do not think that the notion of hiving off different aspects of patient safety work (for example, 'solution' work to NICE) would be at all helpful.

4.8 We believe that the NHS Litigation Authority should be reviewed and modernised. We see the existence of a body such as the NHSLA as a major advantage. However, we perceive that so far there has been a massive missed opportunity to learn lessons from the clinical negligence claims which the NHSLA deals with. We would like to see evidence in the future of tangible steps which have been taken to learn lessons and implement improvements as a result of clinical negligence claims. This will require closer working with the NPSA.

4.9 We believe the NHSLA is the wrong body to be responsible for developing and monitoring safety standards. Currently, they are, in the form of their "risk management standards". Whilst it is important that lessons from NHSLA's work inform standards for improving safety, we believe it is wrong to have responsibility for standards underpinning patient safety with what is essentially an organisation with an insurance industry approach. This work would more appropriately be handled by another agency/agencies such as the NPSA and Care Quality Commission, so that standards are informed by other areas of their work.

4.10 An example of how far the NHSLA is from an understanding of patient safety culture came as recently as August 2007 when it re-issued old guidance on 'apologies and explanations' to all trusts. This circular confused apologies with more 'expressions of regret' or 'sympathy' and actually warned NHS bodies that "care must be taken on the

dissemination of explanations so as to "avoid future litigation risks"". Ironically, under the NHS Redress Act, the NHSLA could be the body responsible for the NHS Redress Scheme which relies on NHS bodies proactively telling patients/families that they may have a potential claim which would be successful in tort.

5 "What the NHS should do next regarding patient safety"

5.1 In addition to the points made above and summarised in the executive summary (paragraph 1), we recommend that the start that has been made in increasing lay/patient involvement in improving patient safety through the 'NPSA/AvMA Patients for Patient Safety' project is further developed. Whilst the recruitment and support of a national network of 'patient safety champions' is a useful start and provides a focal point and resource to develop more widespread patient involvement, it is not an end in itself. A fully developed project would see more 'champions' recruited and supported, but also a wider ranging network, support and training for other patients to actively engage in work on patients safety, and also for staff to help them engage with patients effectively.

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