APPG on Patient Safety Meeting
Tuesday 10th March 2009

The APPG meeting was the first of the year and welcomed the Health Foundation as the official supporters for 2009, taking on responsibility of secretariat from Baxter Healthcare. The meeting was specifically aimed at providing a selection of key stakeholders the opportunity to engage with the members of the Patient Safety APPG and the speakers:

Stephen Thornton (Chief Executive, The Health Foundation)
Dr Peter Cavanagh (Consultant Radiologist at Taunton and Somerset NHS Trust)
Lesley Bentley (Chair, Patient Liaison Group in Royal College of Surgeons, England)

Stephen Thornton briefly introduced the work of The Health Foundation and highlighted key medical milestones that have impacted on patient safety as outlined in the charities information pack. Mr Thornton went on to discuss areas of the medical profession that The Health Foundation has recognised as positively impacting on the sector. This included:

1. The agreement between leading professionals such as Lord Darzi's and David Nicholson that quality should be the organising principle of the NHS
2. The emphasis on addressing MRSA and C Difficile, which has led to a significant drop in the number of cases
3. The roll out of the Safer Patient Initiative
4. The establishment of national reporting and learning programmes that have been put in place

Nonetheless Mr Thornton was keen to highlight that there was still work to be done, such as tackling the 850,000 errors recorded in the NHS and that there is still no coherent strategy for patient safety. He recommended that energy and enthusiasm in the NHS needed to be built upon, ensuring healthcare professionals are proud of where they work, thus reducing the individualistic blame culture that is evident in some institutions. Finally Mr Thornton concluded by emphasising the importance of the Safety Patient Initiative and its recommendations; to continue to work towards transparency and address the skills gap across the UK.

Dr Peter Cavanagh began his presentation with the fictitious story of Mary, an elderly lady suffering from pneumonia. Dr Cavanagh highlighted, by using the story, the patient pathway and how patient safety is a product of the healthcare system. He went on to categorise a safer system into 3 categories:

1. Reliable measurements and processes
2. Continuity of care; "Hand-Offs" from doctors was highlighted as a key aspect of healthcare that impedes on patient safety and needed to be improved, as processes can be repeated or forgotten about
3. Leadership at all levels is needed by providing a 'will' within the organisation that can create a more open, transparent culture and encourages execution and focus

Lesley Bentley shared with the group the viewpoints of patients in the Patient Liaison Group at the Royal College of Surgeons. She proposed that the key areas of patient safety that patients feel need addressing were:

1. Infections; the NHS needs to move away from the knee jerk reaction of dealing with hospital acquired infections and ensure that data on safety is accurately collected and sorted by encouraging a culture of accurate reporting. Ms Bentley used the phrase that you shouldn't use a smoke detector as a timer when cooking to emphasise these points.
2. Blame culture; Ms Bentley echoed the points made by Stephen Thornton and Dr Cavanagh that patient safety issues are not addressed or recorded because of the blame culture within the NHS needs to be addressed in order for the problem to be dealt with. She recommended that a more formal, constructive channel of reporting

incidents or concerns about colleagues need to be put in place. Moreover the data and performance outcomes need to be published to ensure incidents are used to drive up standards

3. Patient pathway; there are inadvertent results that become policy targets because the patient pathway has become too fragmented and continuity of care has been lost. The Royal College of Surgeons Patient Liaison Group want to know that healthcare professionals involved in all aspects of the patient pathway are aware of each others' processes, otherwise lessons cannot be learnt and patient safety improved upon. The idea of a production line process, whereby people are responsible for their individual 'section' is impacting upon patient safety
4. Clinical rationale vs economics; the NHS and Government needs to be aware that patients don't want long waiting times but also do not want short waiting times at the expense of safety. Economics should not dictate behaviour nor the bottom line be used as a guide of best practice
5. Working Time Directive; there is concern among the RCS that hospitals and healthcare professionals are not ready for compliance with the Working Time Directive, particularly when it involves training on the job and they are concerned that patient safety will be inflicted because of this.

The presentations were followed by an informal Q&A session that gave attendees the opportunity to interact and discuss issues of patient safety. The discussion will help towards shaping the agenda for future meetings in 2009 and 2010.

Professor Brian Toft from Coventry University instigated a heated debate about safety versus quality. Mr Toft referred to Stephen Thornton's quote that "Quality should be the organising principle of the NHS" and claimed that the organising principles of the NHS should be safety not quality. To which, Stephen Thornton responded that safety was one dimension quality, along with other aspects such as efficiency and access, all of which contribute to patient safety. Dr Cavanagh agreed, claiming that quality and safety were intrinsically linked and therefore cannot be addressed as single entities when it comes to patient safety.

Guy Hirst and Trevor Dale from Attrainability, who have submitted evidence to the current Health Select Committee into patient safety, highlighted that complacency, individualism and a culture of shifting blame that dominates the NHS has serious effects on patient safety. They called upon the Department of Health to seriously consider methods to tackle the embedded ideology. Howard Stoate announced in response that systems and teams are more advantageous than individualism and it is something the Secretary of State for Health, Alan Johnson is looking into.

Esther Thompson from the International Alliance of Patients' Organisation reflected on Dr Cavanagh's hypothetical story of Mary and claimed that many patients were experts in their own care; therefore there needs to be more of an emphasis on patients and their carers' views. Dr Cavanagh concurred and argued that it is only the patient and their carer(s) that experience the patient pathway in its entirety and therefore needed to be included in addressing patient safety. Thus the 'them' and 'us' attitude in the NHS needed to be replaced with a holistic view of treatment. Stephen Thornton made the important point that we lived in times when the patient is empowered with more information and has become an 'expert' but clinicians aren't aware of how to deal with this.

For further information on the APPG for Patient Safety or forthcoming meetings please go to the Group's website: http://www.patient-safety.org.uk/home.htm or contact Natalie Bateman on 0207 618 9100.