Clinical Vice President at the RCP and now Clinical Advisor to MMC at the Department of Health (DH), emphasised the importance of collaboration between the profession and the DH. In the same issue, Margaret Turner-Warwick (2008;8:573–5) also reminded us of the importance of the patient–doctor relationship and the links between the professions and government. The omens for August 2009 look promising but continuing constructive debate within and outside the chapterhouse will still be needed.

Reference

1 Core medical training recruitment. www.rcplondon.ac.uk/education/cmt/Pages/Overview.aspx

Spasticity in adults: management of botulinum toxin

Spasticity is a distressing symptom and any improvements in treatment are welcome. The RCP has recently published evidence-based national guidelines on the management of spasticity using botulinum toxin. The guideline development group, chaired by Lynne Turner-Stokes, is to be congratulated on a guide which is a model of clarity to describe the effective and appropriate use of botulinum toxin. The full document can be purchased at **www.rcplondon.ac.uk/pubs/brochure.aspx?e=272**

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European Union patient safety

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In this issue, Lee McGill describes recommendations on patient safety from the European Commission, including the prevention and control of healthcare-associated infections, which it is hoped will be adopted in 2009 (pp 136–9). What might these recommendations contribute to improving patient safety and what are the implications for physicians and clinical teams?

McGill refers to the earlier technical report entitled *Improving patient safety in the EU* which states that between 8% and 12% of patients admitted to hospitals suffer from adverse events while receiving healthcare.[1] These figures are similar to reports from Australia and the USA and while many of these adverse events are recognised and dealt with before patients suffer harm, the impact of such incidents on patients and their families can be substantial: they often add to the costs of care, may increase in-hospital stay, and some result in litigation. Healthcare staff involved in serious incidents may be traumatised and develop stress-related illness. There is now widespread acceptance that healthcare providers should strive to improve quality of care and patient safety by developing better processes and system delivery. Importantly they need to contribute to risk management systems designed to record information on adverse outcomes and safety incidents.

The National Patient Safety Agency (NPSA) was established in the UK in 2001 following the publication of *An organisation with a memory* by the Chief Medical Officer.[2] The NPSA is a special health authority with a core function to collect and analyse information on patient safety incidents in England and Wales. It has developed the NHS Reporting and Learning System (RLS) which is the most comprehensive national reporting system in the world with over three million incidents on the database and around 80,000 cases reported by NHS staff each month.

Voluntary reporting systems have well-recognised limitations.[3] The NPSA has developed a novel approach in analysing these incidents in order to better inform the NHS and others of specific high-risk practices and to suggest actions to improve safety in these instances. Such alerts are published as rapid response reports and are available on the NPSA website. Unfortunately, incident reporting is variable and detects only a minority of adverse events.[4] Reporting between trusts is varied and low reporting by senior medical staff is common. Various reasons have been advanced for this including the time involved, the perception that it will make little difference or that the incident has been dealt with and thus no further action would be helpful. Clinicians often describe their frustrations that, even when detailed incidents are reported, trust management often fail to support change due to competing priorities. Some may fear that disciplinary action may be taken. In this, the European Commission's recommendations are most helpful since they emphasise the importance of blame-free reporting as the basis of a successful

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programme to reduce risk. Nevertheless such concerns are understandable and are not helped by the considerable media scrutiny which can follow safety events.

What can physicians do to help? Vincent and colleagues have argued for the need to develop more systematic measures to improve safety and have stated that there is little real hope of engaging clinical teams without better collection of local data that are relevant to their area of practice.[3] A similar conclusion is indicated by the King's Fund inquiry into safety of maternity services.[5] Physicians should increase awareness of patient safety and recognise that it is their professional duty to ensure safe systems of care. They need to highlight understanding of safety issues for the whole clinical and management team. There needs to be renewed emphasis on patient safety training for future physicians which is referred to in the recommendations. This training should include an understanding of the importance of human factors in safe delivery of care by improved teamworking which stresses the equal value and responsibilities of all team members in ensuring the safest possible care. The World Health Organization's Safer Surgery Saves Lives initiative is an example of this with the introduction of pre- and postoperative checklists to be completed by all theatre staff.

Incident reporting, which provides the opportunity to learn lessons and to contribute to the national database, is especially important and physicians should take a more active role in this. For example, cases discussed during a ward round which involve errors of diagnosis or treatment should be reported to risk management. Even 'no harm' incidents can be invaluable in providing the NPSA with information on the frequency of a problem. Issues of particular relevance to medicine include errors of diagnosis following acute admission (one of the most hazardous events in patient care), prescribing errors, problems in interpretation, and delays in laboratory and radiological reports.

It is not all bad news. Hospital standardised mortality ratios show significant falls in recent years.[6] There are also encouraging signs of a reduction in hospital-acquired infection with some evidence of the effect of the NPSA's Clean Your Hands campaign. The Royal College of Physicians (RCP) has developed a close relationship with the NPSA and shares information working with a number of the medical specialties. More can be done and it is hoped that when new safety issues are identified, specialties will discuss them directly with the NPSA.

Patient involvement is vital to gaining public confidence and understanding of safety issues and perhaps this is an area in which the RCP could contribute via their Patient and Carer Network? In England there is now an active Patient Safety First campaign which has strong patient representation. It is encouraging to see how the public education campaign concerning the value of hand washing has gone some way to ensuring that healthcare workers comply with this most basic of safety procedures.

In summary, the recommendations when accepted should bring further emphasis and international support for the importance of patient safety in providing improved healthcare across the EU. Perhaps this will ensure that safety is placed at the centre of healthcare provision and that all new developments, whether concerned with diagnostic testing, therapies, procedures or organisation of healthcare, are always carefully risk assessed before implementation. I suggest that for all new developments patient safety has to be formally considered. As an example, the possible effects on patient safety following implementation of the European Working Time Directive may not have been adequately considered.

References

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4 Sari AB-A, Sheldon TA, Cracknell A, Turnbull A. Sensitivity of routine systems for reporting patient safety incidents in an NHS hospital: retrospective patient case notes review. *BMJ* 2007;334:79–82.

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