

The Minutes of the meeting of the Derby Medical Society

Held on 22nd September 2015 in the Derby Medical School

Apologies: none received

Welcome: Mr S Iftikhar, outgoing President

Deaths of members: The Society noted with sadness the deaths of Mr Joe Darné and Mr Howard Jenkins (both retired Consultant Obstetricians and Gynaecologists)

Minutes for the meeting 24th March 2015: Read by Mr Stephen Milner, Junior Secretary, and approved.

Presidential Handover: to Dr John Charlton (General Practitioner).

Guest Lecture: Dr Maureen Baker, Chair of Council of the Royal College of General Practitioners – “Staying safe – people and systems in health care”

Dr Baker noted that medical error was the 5th highest cause of death in the USA in 1999, accounting for approximately 98,000 deaths per year. This is more than road traffic accidents, breast cancer or AIDS.

The healthcare industry has a lot to learn from other safety-critical industries, such as air transport, railways, oil and gas, where organisational learning is better established. The need to develop this in healthcare was highlighted in Liam Donaldson’s report “An organisation with a memory”. Just as in industry, errors in healthcare result from complex interactions of local conditions, human factors, social factors and organisational weaknesses.

Reason (1990) stated that human error is inevitable, but that it is possible to change the conditions in which people work in order to minimise the opportunities for error. Adverse factors that combine to result in an error can be categorised as ‘self’, ‘context’ and ‘task’, and a particularly dangerous situation is described by the acronym ‘HALT’ – Hungry, Angry, Late, Tired. Fatigue is a particularly potent cause of error, which is why working hours are strictly limited in safety-critical industries. There is a case for stronger working hours regulation in healthcare.

In healthcare, 70% of adverse incidents may be preventable. There is a counter-productive blame culture in the popular press. Incidents are rarely due to a single error, and prevention needs to address systems as a whole. This requires a Safety Management System as in other industries.

The National Patient Safety Agency (NPSA) has published a safety framework for the NHS “Seven Steps to Patient Safety”, comprising:

- Safety culture
- Leading and supporting staff
- Integrated risk management
- Promoting reporting and learning
- Patient involvement
- Learning and sharing lessons
- Solutions to reduce harm

Questions included:

- The effect of 10 minute consultations on patient safety
- The reasons for excess mortality in hospital at weekends
- The role of National Confidential Enquiries
- The relationship between safety and risk aversion
- The effects of fatigue in General Practice, and the role of other professional groups
- The effect of proposed contract changes on patient safety

Vote of thanks: Given by Dr Stuart Holloway

Register: signed by 33 members, 8 trainees and 3 guests

Next meeting: 6th October 2015

.....

Date:

Dr J Charlton, President