



Patients for Patient Safety Project Newsletter

Volume 1, Issue 1

July 2008



National Patient Safety Agency

Patient Safety Champions recruited

This newsletter has been developed to keep the wider network informed of news and developments including the patient safety champions initiative.

The first edition focuses on the recruitment of the Patient Safety Champions but we'd like to hear from you with your concerns, issues and items of interest around improving patient safety.

Please contact the Editor: Anna Allford at AvMA; email: anna@avma.org.uk

Or write or phone (details on the last page).

Recommendation 13 of Safety First (Department of Health, England, 2006) called for the development of a network of 'patient safety champions' drawn from patients and the public, to work with the NHS to improve patient safety by bringing patient experience and perspectives to this work. The rationale was that experience around the world shows that it is in the countries where there is such involvement of patients that work on patient safety is most successful.

The recommendation was that the initiative has close links to the Patients for Patient Safety (PfPS) workstream of the WHO World Alliance for Patient Safety which has pioneered the concept of patient safety 'champions'.

A call for volunteers was launched at a meeting for

patients and healthcare professionals with an interest in patient safety, in March by the charity AvMA (Action against Medical Accidents) in partnership with the National Patient Safety Agency (NPSA). Twenty two people attended a two day Induction Workshop in London, on 20th and 21st May as part of this first wave of in-country Patients For Patient Safety Champions selected to represent England and Wales. Additionally, 10 healthcare professionals from Strategic Health Authorities (SHAs) in England and 1 member of the Patient Safety Action Team in Wales joined the Workshop on day two.

Patients, their carers or patient advocates met together on day one of the Workshop to share their personal stories and experience of what happens

when things go wrong in the care provided by the NHS (National Health Service). Common themes emerged around errors in treatment, diagnosis and care, and many people expressed dismay at the culture of denial which persists among healthcare professionals in the aftermath of a serious incident. Much discussion featured on the failures in policy and process to address the issues and prevent similar incidents and accidents from recurring. A key principle of the initiative is not to duplicate or replace existing work on patient safety or on involving patients and the public in patient safety work, but rather to complement and support it. In future, through this initiative, Patient Safety Champions will be supported to provide the patients' perspective in improving patient safety at all levels; locally, regionally and nationally, throughout England and Wales.

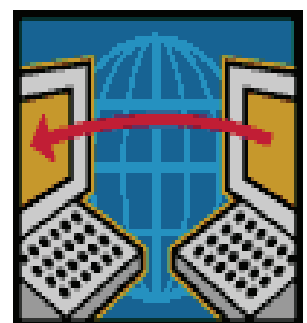
Stop Press!

The Report of the Induction Workshop is available on the AvMA website to view or download. Go to the *Patients for Patient Safety* section of 'Sharing Experience' (tab at the top of the AvMA Home page) www.avma.org.uk

Join in Discussion Forums on AvMA website

As a member of our wider Network you can now register for Discussion Forums on the AvMA website. Join our private 'Patients for Patient Safety Network' and post your interests or comments for others to read and respond to. There are also two other areas: one for the public to make suggestions for

improving patient safety; and a private area for the Patient Safety Champions to exchange information. **Date for your diary—July 30th at 1pm—log on to the Patients for Patient Safety Network to discuss 'Being Open'**. Information about Being Open can be found on the NPSA website: www.npsa.org.nhs.uk



Network with other people

Update on Champions and NHS Partners in England and Wales

This is just a quick round-up of what has been happening since the Induction Workshop in May. If any Champions and their NHS partners have some further activities or meetings planned, we'd love to hear about these.

- The Quality Safety Team for NHS East of England met on 16th June with Patient Safety Champions; Marlene Moura and Peter Metherall.
- NHS Yorkshire and The Humber have a 'meet the team' day planned with Champions; Dr Narendra Mathur, and Iain Wordsworth on 29th July.
- On 7th August representatives of NHS North West will be meeting Patient Safety Champions; Ann

Bisbrown-Lee and Bev Hurst.

- Champions; Simon Mathias, and Graham Tanner have a meeting scheduled for 1st September with NHS South West.
- In the North East, Champions; Mike Casselden, and Margaret Ogden have commented on and contributed to a draft Patient Safety leaflet produced by the SHA. There is also a meeting planned on 31st July to which they have been invited.
- A meeting date of 31st July has been scheduled between NHS Southeast Coast and Champions; June Hitchcock, and Darren Tamplin.

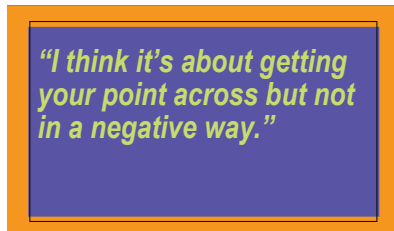
- The Patient Safety Action Team (PSAT) representative from NHS West Midlands has produced a summary paper to present to her PSAT colleagues on 7th July and will feed back afterwards to the Champions; Beryl Nock and Brian Osborne.
- In Wales the PSAT representative has met with the '1000 Lives' Campaign team to discuss ways that the Champions; Meryl Davies and Stuart Stevenson can contribute to their work. She has also planned a training session locally for them.

Speaking to your MP

Bev Hurst, Patient Safety Champion, has a good working relationship with her MP and suggests this might be a useful way of getting across your points. She says "I had been extremely vocal about the patient safety issues regarding a certain trust – done newspaper interviews and TV interviews etc – I then made an appointment to see him and straight away he said 'I

realise we have differing political views but as a constituent of mine I will work 200% for you' and he always has done." Once he realised she wanted some accountability and truthful answers they forged an excellent

working relationship and her MP was ultimately responsible for getting the public patient stakeholder group for the cleaner hospitals



programme (Janice Stevens is the Director for this programme) started. He also gave her some great leads to contacts in other Departments.

Bev concludes "at the end of the day we are all potential clients of healthcare so it's in all our best interests to promote patient safety."

Raising Awareness



Simon Mathias, Patient Safety Champion, in the South West, has been contacted by his local newspaper

for some information about his role as 'Champion' and AvMA has supplied a short update to supplement his own story. If any other Champions need a similar background article please do let Anna Allford know.

Patient Safety Champion for Wales, Stuart Stevenson, has found it really useful to give out copies of the 'Role Description' for Champions when he meets people. He said "the consultant

who has been looking after me for the last 9 years had heard of the project and was pleased it was me. He then offered his services whenever I needed it."

Marlene Moura, Patient Safety Champion, East of England, has found her Certificate from the World Alliance for Patient Safety useful to support discussion with senior NHS staff.

Coroners (Amendment) Rules 2008

The Coroners (Amendment) Rules have been laid in Parliament and will come into effect on 17 July.

The Rules amend the Coroners Rules 1984 as follows.

1. Rule 43 amended

Rule 43 has been amended to strengthen coroners' powers to make reports where they consider action should be taken to prevent future deaths. Amongst the new requirements:

- organisations receiving a report must respond to the coroner in writing within 56 days outlining what action, if any, is being taken – or, if no action is planned, an explanation as to why;
- coroners will be required to share

the reports and responses with interested persons to the inquest (including family members), and with the Lord Chancellor; and coroners and the Lord Chancellor will have the authority to share reports and responses with any others who might find them useful or of interest.

2. New Local Safeguarding Children Boards (LSCBs) rule added

A new rule (rule 57A) has been added concerning the supply of information from coroners to LSCBs (which were established to protect and safeguard children in their local area and have a responsibility to conduct a review when a child under 18 years old dies).

Rule 57A requires that:

- coroners notify the appropriate

LSCB when the death of a child is reported to them; and

coroners are able to share information that may be of use to the LSCB for the purposes of their functions.

A copy of the Coroners (Amendment) Rules 2008 and the accompanying explanatory memorandum is being made available on the Office of Public Sector Information website www.opsi.gov.uk

Wider Involvement Network

To improve the way in which we communicate with you as part of AvMAs network of about 150 individuals who have experience of medical harm, or an interest in improving safety for patients, Anna Allford, Project Manager, will shortly be sending out a survey to those who became members before May 2008.

Please do respond to this as we'd like to know how you want to be contacted e.g. email, postal etc. Also we want to know what types of involvement you

want. For example, some people may only want occasional updates in the form of this newsletter, whilst others may want a range of options made

"We'd appreciate knowing a little more about you and your background..."

available such as attending meetings, reviewing information or taking part in surveys to find out your views and opinion on aspects of patient safety.

It is anticipated that your concerns and issues will also contribute to the broader agenda around patient safety and be highlighted through the work of the Champions. We'd appreciate knowing a little more about you and your background too. Of course, all this will be confidential, so look out for our Survey in your inbox or through the post.

Patient Safety Champions announced at the Patient Safety Congress

Speaking at the Patient Safety Congress 2008 at ExCel, London in May, Peter Walsh, Chief Executive of AvMA announced the recruitment of the 22 Patient Safety Champions. He also called for NHS staff to be legally mandated to report patient safety incidents.

The Congress ran for 2 days and conveniently followed on from the Induction Workshop for Champions and NHS partners.

David Nicholson, Chief Executive, NHS, stated that there is a need to redesign care to make it safer and asked for openness, honesty, forgiveness and teamwork. A need to learn from mistakes was stressed by Sir Liam Donaldson, Chief Medical Officer, Department of Health & Chair, WHO Alliance for Patient Safety.

Professor Christine Beasley, CBE, Chief Nursing Officer, Department of Health, described the power of

patients' stories and the need to work with local patient groups to include the patients' perspective. This was reinforced by Professor Bruce Keogh, Medical Director, NHS, describing the strength that patient and family involvement provides in the way that services are developed.

The Congress will be held at The ICC, Birmingham next year between 30th April and 1st May.



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The National Patient Safety Agency (NPSA) helps the NHS learn from its mistakes so that it can improve patient safety. It does this by collecting reports on errors and other things that go wrong in healthcare so that it can recognise national trends and introduce practical ways of preventing problems. It does not investigate individual cases or complaints, but it does listen to public concerns and uses what is said to improve safety.

Action against Medical Accidents (AvMA) is the registered charity (number 299123) which promotes better patient safety and justice for people who have been affected by medical accidents. AvMA believes that whatever the cause of medical accident, the people affected deserve explanations, support and where appropriate, compensation. It provides free independent advice and support to patients harmed as a result of errors or omissions in healthcare and provides training and accreditation for solicitors working on behalf of people who have been affected, and a range of other educational events. AvMA also campaigns for improved patient safety and ways of responding to patients when accidents do occur, and works in partnership with others to achieve a more open and fair culture.

Round up of other news of interest

General Medical Council (GMC) reform

As part of the reform process the GMC are to run two pilots of how the new roles of Responsible Officers and GMC Affiliates (including 'lay' affiliates) could work. The areas chosen are Yorkshire & Humberside and London (specifically Camden Enfield and Haringey). Strangely, the GMC has decided that the 'lay' GMC affiliates will be members of its own staff! However AvMA has discussed possibilities for building in patient involvement in the pilots and their may be opportunities both for champions and members of the PfPS network to get involved. Let Anna know if you would be interested.

Championing 'Being Open'

Following discussion at the Induction Workshop it is planned to focus priority on promoting "Being Open" and challenging the "culture of denial" referred to in Safety First. There is an event for Champions to develop awareness and strategy in July. Plus there is the possibility of a large event / conference later this year.

CRB checks

Checks will be undertaken by NPSA for all of the Patients for Patient Safety Champions as good practice suggests volunteers should be provided with these.

The Hygiene Code

AvMA have had an enquiry about involving patients in monitoring the hygiene code. We have indicated to the Healthcare Commission that we could involve our wider 'Network' in this and are waiting to hear back from them. It is likely to be in the form of a survey.

Patient Safety Campaigns

Information and links to the campaigns in England and Wales can be found on the NPSA website at:

www.npsa.nhs.uk/patientsafety/improvingpatientsafety/nhs-patient-safety-campaign

Health Professional Regulation

The various working groups set up by the Department of Health to help implement the White Paper "Trust Assurance and Safety" are due to make their

recommendations this year. There is a conference being held by the Department of Health in London on 24th July to report on progress so far. Many stakeholders including members of the PfPS network have already been invited. Two key issues of priority from the patients' perspective have been pursued by AvMA who are represented on some of the sub-groups:

- making reporting of potential clinical negligence claims as well as complaints obligatory for all health professionals. Currently GPs do not have to let a PCT know if they have a potential claim about them for example.

- a helpline and advice and support service for members of the public who may need to report concerns about a health professional's fitness to practise

We are hopeful of seeing recommendations which reflect these needs identified by patients as well as many others on different aspects of the reforms.

For more news visit the AVMA website:

www.avma.org.uk/pages/news.html