

## *The Never Events Framework 2009/ 10 The next stage in implementing patient safety*

*This newsletter has been developed to keep the wider Network and those with an interest informed of news and developments including the patient safety champions initiative.*

*It is now available to view or download on the AvMA website at:*

[www.avma.org.uk/champions](http://www.avma.org.uk/champions)

*This edition focuses on the some of the meetings and events in which Champions have been involved in. Plus items of national interest for England and Wales have been included.*

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You can access both public and private forums on the AvMA website.

Go to [www.avma.org.uk](http://www.avma.org.uk) and click on the 'Share experience' tab at the top of the page. Then go to 'Discussion Forum' in the list on the left-hand side of the page.

This event took place in Manchester on 3 March 2009. It was organised by the National Patient Safety Agency (NPSA) and NHS Manchester.

Bev Hurst, Patient Safety Champion, also represented the charity NCHI (National Concern for Healthcare Infections) of which Bev is a founder and the Administrator.

Laura Roberts CEO NHS Manchester welcomed everyone and was very proud of all the work NHS Manchester had done and the fact that NPSA has chosen to launch 'Never Events Framework'\* in Manchester. This Primary Care Trust (PCT) is embedding patient safety and quality as a priority.

An overview of the patient safety agenda was provided by Martin Fletcher, Chief Executive, NPSA. Martin saw the partnership of NHS Manchester and NPSA as a lever for change that hopefully will be rolled out nationally.

The never events framework for 2009/10 was introduced by Tanya Huehns, Strategic Advisor, NPSA. She described the concept and terminology of such reportable events.

There was a general agreement as to what should 'never happen'. Never Events in the USA are linked to insurance: Minnesota Experience; and MEDICAID.

The UK has taken some influence from the USA – key principles:  
Leadership – Commissioners  
Learning – Boards and commissioners

• Landscape – existing work mechanisms  
• Local/nationals – existing contacts and tools  
• Legal and valid measurement to help commissioners.

Never Events is going to be a staged approach. The 1<sup>st</sup> year will be used to test the process with limited events in Acute Trusts only.

Professor Rajan Madhok, Medical Director, NHS Manchester, described the PCT's perspective around patient safety. He stated that working together as a whole economy works. The provider perspective was presented by Paul Moore, interim Director of Quality Assurance, University of South Manchester NHS Foundation Trust. He outlined some of the risks they had identified:

- Infusion pumps/drips

- Falls
- Medicines
- IT monitoring.

Paul reported that recognising signs of serious illness is a challenge but South Manchester are committed to:

- Save 1000 lives by 2015
- Provide defect free care
- Reduce unintentional harm.

The benefits include:

- ⇒ Health Care Associated Infections are reduced
- ⇒ Patient/staff satisfaction is increased
- ⇒ Reduced length of stay.

The whole onus of the day was that professionals have to include patient involvement and also had to employ 'being open' to provide a safer culture for all.

The event gave Bev and Sue Bothwell, Assistant Director Patient Safety Improvement, NHS Northwest, the chance to network with other organisations in the area with a view to securing networks for the Patient Safety Champions.

**Bev Hurst,  
Patient Safety Champion**

\* NPSA website:  
[www.npsa.nhs.uk](http://www.npsa.nhs.uk)

# PATIENT SAFETY SUMMIT MASTERCLASS

## Birmingham 21<sup>st</sup> April 2009

Beryl Nock, Patient Safety Champion and Anna Allford, Project Manager attended this summit designed to look at Serious Untoward Incidents (SUIs) and how the SHA's policy for this will be revised in line for the forthcoming transfer of procedures to PCT (Primary Care Trust) Commissioners for monitoring these in June 09. The emphasis was on how everyone needs to work together to manage SUIs – across PCTs, hospital Trusts, Foundation Trusts and SHA (Strategic Health Authority) Patient Safety Action Teams (PSATs) and to share the learning from incidents. In particular 'Never Events' such as 'wrong site surgery' or 'intravenous administration of mis-selected concentrated potassium chloride' should as it is suggested never happen. See National Patient Safety Agency (NPSA) website for policy and tools to implement this: [www.npsa.nhs.uk/nrls/improvingpatientsafety/neverevents](http://www.npsa.nhs.uk/nrls/improvingpatientsafety/neverevents)



The day included a presentation from Jan Willetts, HM Inspector for Health and Safety Executive. Jan described the ways in which safety could be improved generally in the NHS and the duties of employers to staff

plus the duties towards patients, visitors and contractors on NHS premises. Jan also briefly explained the guidance for the Corporate Manslaughter and Corporate Homicide Act 2007. More information can be found on their website: [www.hse.gov.uk](http://www.hse.gov.uk)

Heather O'Neill, Head of Patient Safety and Quality, at the West Midlands SHA discussed the reasons for reports and how current reports needs robust monitoring and audit, especially as so many remain not closed unnecessarily. Manjeet Garcha, Patient Safety Manager, described the tools available and the support that NHS West Midlands will continue to provide.

The final presentation of the morning was from David Heel and Fiona Goodall, Area Managers, Care Quality Commission (CQC). They gave an overview of the new role of the CQC and it's responsibilities as the Regulator for quality in health and social care (adults social care only, OFSTED looks after children's and young people's social care). In their safety and safeguarding role they are however, responsible for healthcare for children and young people. CQC is accountable to the Secretary of State for Health. It is the intention of CQC to include a selection of Commissioning PCTs in their Annual

Health Check this year. In 2010 the fully extended powers of CQC will come into force. For more information about this Regulator see the website: [www.cqc.org.uk](http://www.cqc.org.uk)

An interactive session took place in the afternoon with Dr Khesh Sidhu, Deputy Medical Director, NHS West Midlands, introducing the tasks to examine some real reported SUIs and help develop a framework for organisations in the West Midlands to share around what should be in reports, what should be audited and how the information and learning can be disseminated to produce a standard operating procedure for SUIs. The NPSA will be developing a new framework and this will be consulted upon in the region in the next few months but it was felt that today's workshop could feed into this process and prepare the way.

Further quarterly events are planned by the SHA around patient safety and suggestions for topics were called for. Beryl and the project team look forward to working with the SHA to include the patients' perspective in all workstreams around patient safety improvements.

## Over 400 lives saved in first six months of 1000 Lives Campaign



The 1000 Lives Campaign has estimated that an additional 410 lives have been saved by NHS staff in its first six months. The figures for the period April to September 2008 were released today (April 21, 2009) to mark the first anniversary of the all-Wales patient safety campaign. They reflect the action taken by NHS Trusts and Local Health Boards to improve the quality and safety of healthcare across Wales. Building on existing initiatives and good practice, improvements have been made in a number of key areas providing a new standard of care for many patients.

Campaign director, Dr Jonathon Gray said: "The commitment and engagement of NHS staff has been excellent. Alongside the good work already taking place, they have also developed new ways of working to deliver safer and better quality care to patients throughout Wales." "There is a shared goal of ensuring that safe healthcare becomes a matter of routine. This is a great start - but we know there's so much more to do..."

See the campaign website for more news and information, go to [www.wales.nhs.uk](http://www.wales.nhs.uk) and click on the Campaign logo

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



June Hitchcock and Darren Tamplin, Champions working with South East Coast (SEC) Strategic Health Authority (SHA), continue to review the policies around Being Open of all Trusts in their region and will share the findings with the SHA. June has been invited to the SEC SHA Quality Board and when she is not available Darren will attend in her place.



Graham Tanner, Champion in the South West region, had a meeting with the Director of Patient Safety at Gloucester Hospitals NHS Foundation Trust, together with Anna Allford, Project Manager. They discussed patient safety initiatives at the hospitals where the input of patients/families/carers would be particularly welcomed. Graham will keep in touch to progress his involvement as a Champion and Anna will consider the role of the Wider Network and Associate Patient Safety Champions locally for future working.



Beryl Nock, Champion in West Midlands, will be attending a public meeting in Stafford on May 5th. It has been organised by the Patient Support Group 'CuretheNHS', the group campaigning about hospital care in Mid Staffordshire. Peter Walsh, AvMA's Chief Executive, and Anna Allford, Project Manager will also attend.



## Wider Involvement Network

We are keen to hear how you would like to see the project develop in the future and also to get your thoughts about information you want in addition to what has been useful to you already.

Anna Allford, Project Manager will be sending out a questionnaire in May which will help identify how the project can make recommendations for the development of Patient and Public Involvement (PPI) in patient safety more generally, based on the experience of the project thus far.

**Give us your views about the project to date and how you'd like to see it develop in future**

To support the development of the project Anna will also undertake a small number of in-depth interviews with those involved more closely in the project.

Please do respond to this very important survey. Information collected will be anonymised for confidentiality.

For further information please contact Anna

Email: [anna@avma.org.uk](mailto:anna@avma.org.uk)

## RCA (Root Cause Analysis) investigation Summit

Bev Hurst, Patient Safety Champion, attended this meeting in Manchester on 9 April 2009 on behalf of NCHI in addition to representing the Champions network.

Donna Forsyth, Head of Reporting & Local Improvement NPSA, introduced the day. Donna joined NPSA as a Patient Safety Manager in 2003 and was appointed Head of Reporting & Local Improvement in March 2008. Leading on incident investigation she has worked with the World Health Organization's (WHO) 'high 5s' team to develop an impact evaluation strategy for Event Analysis and is currently developing tools and systems to capture learning from patient safety investigations.

Donna gave an overview of the new RCA writing tools and John Morrison, Patient Safety Manager, NHS East of England, gave an IT demonstration on how to use the template: downloading it from the NPSA website, to using and uploading.

More information can be found on the NPSA website: [www.npsa.nhs.uk](http://www.npsa.nhs.uk)

John also discussed 'Human Error' and James Reason's *Swiss Cheese Model*. He said human error is a reality: humans as hazards. This is the basis of 'Human Factors'. John showed a DVD of Martin Bromiley

giving examples of human factors in the airline industry and the case study of failures when his wife died in theatre whilst being anaesthetized. The video can be viewed on the website of Clinical Human Factors Group (CHFG): [www.chfg.org](http://www.chfg.org)

John introduced two models of error:

- Personal: blame – deny -isolate
- System: learned - helplessness

He said both extremes have pitfalls and that the system needs to be designed to alleviate error. An example given was front loading washing machines. When they first came in many flooded kitchens so they were redesigned to engage a lock in order to avert flooding.

Alison Walton, Patient Safety Consultant, NHS South East Coast, presented 'Being Open – Experiences from the front line'. She gave a case study from Brighton where the patient safety lead was very responsive and communicated at every step with the family despite the legal team not being accommodating because it felt open discussion would mean admitting liability.

Alison described barriers to Being Open:

- Clinicians fear of litigation
- Culture: open blame

Alison suggested a quick response to engage with patients led to less complaints because they are dealt with at source. She also said staff will respond more and report more if given feedback on incidents therefore they are more likely to engage.

Donna presented the 'RCA data capture – dataset for 'son of STEIS'. STEIS (Strategic Executive Information System) is the software system which allows NHS and Department of Health users to report and view Serious Untoward Incidents (SUIs). NPSA only collect patient safety incidents now to take up RCA via PATIENT SAFETY DIRECT which is hoped will start in June 2010.

A new national SUI policy is being drafted and there is a consultation in process. Donna urged everyone to use the new template for RCA and forward it as soon as possible to the NPSA. There is a draft RCA database reflecting the WHO international classification for patient safety (ICPS) framework.

**Bev Hurst,**

**Patient Safety Champion**

*There is a training session in Root Cause Analysis for Patient Safety Champions only in early May. If any Champions wish to attend please contact Anna Allford by May 5th.*

## Patient Safety Congress 2009

This year some of the Patients for Patients Safety Champions from the project in England & Wales will not only attend the Patient Safety Congress but 2 champions will be Speakers alongside Anna Allford, Project Manager.

The Congress will be at the ICC in Birmingham between 30 April and 1st May.

Anna commented "Last year in May after the Induction Workshop I said that in 2009 I'd love to see these Champions presenting at the Congress." She continued "This is exactly what we'd hoped for— Champions talking about how they have worked in partnership with their NHS Partners to improve patient safety."

More information and news from the Patient Safety Congress will be in the next edition of the Project Newsletter

# Using Web 2.0 to Improve Patient Safety

*Harnessing the power of patients' and carers' observation, experience and group-intelligence*

On 20<sup>th</sup> April a Workshop took place in London to generate ideas around using the internet to provide new and complementary information that could be used by healthcare professionals and organisations to improve patient safety. Relevant stakeholders had been invited by the National Patient Safety Agency (NPSA) and this included Stuart Stevenson, one of the Patient Safety Champions for Wales. Anna Allford, Project Manager, also participated and Gillian Bean, Patient Safety Champion, represented the patient support group *SIN* (Sufferers of Iatrogenic Neglect).

Dr Neil Bacon gave a brief explanation of what is Web 2.0 and provided some features plus background together with the distinction between what the earlier version of the World Wide Web was capable of. Debate around whether 'Web 2.0' is just marketing hype was set aside so that we focused on what ideally we could do with the fantastic tools that exist to capture, store and collate data together so that you and I can press buttons to magically get the information we want.

Web 2.0 allows for: co-operation; collaboration; inter-operability; openness and a sharing of information to other websites; and it is dynamic in that it is added to by users.

Some examples of this included a site called Amazon that sells books, CDs, electricals etc. Users of this site are encouraged to give feedback on the goods they have purchased for other members of the public to read which enables you to be part of a community. Together with your user profile details and history of purchases, it cleverly makes suggestions for you to buy goods when you enter the site. Social networking websites are also good examples of Web 2.0 such as those used to keep in touch with friends or share photos.



- Allow recommendations for potential pilot projects and next steps.

Participants were divided into groups with the remit to suggest a way(s) of using the Web or multi-media to get patient/carers/family and staff feedback or an 'early warning' system for certain safety issues. Some excellent ideas were generated including: a Cardiac patient interactive care pathway; a hospital route map/clinic waiting times update device (similar to a SatNav) to guide you through hospital car parks and large complex hospital buildings; and reporting systems in real-time to let organisations know of concerns over safety issues such as wheelchairs blocking fire exits or from patients who feel they have experienced harm in NHS care. Some of the ideas will be taken forward and explored further and we look forward to hearing more on developments in the future from NPSA.

The aims of the workshop were to:

- Explore the relevance and possibilities of using Web 2.0 techniques to collect information from patients, carers and healthcare staff
- Consider strengths, weaknesses, opportunities and risks of such an approach
- Assimilate the views and initial discussions from relevant stakeholders including the NPSA, healthcare professionals, patient groups and those with experience of using the internet/Web 2.0 in healthcare

## Involvement Awards 2009 launched

*The NHS Centre for Involvement announced the launch of their involvement awards for this year. Please find below this announcement from their newsletter.*

We are rewarding innovation and imagination in Patient and Public Involvement (PPI) through a new national awards scheme.

The Involvement Awards 2009 are a celebration of the extensive work being undertaken by NHS, the voluntary sector and social care organisations in their engagement and involvement of patients and the public in health and social care services.

We are looking for projects which have used an imaginative and ground-breaking approach to PPI to showcase their work to a national audience.

The Awards are in two categories – Commissioning and Provider – and the judges are looking for projects which can also demonstrate the real impact and sustainable change PPI has had on services.

The winner of each category will be awarded a prize fund of £5,000 to use to share the work and findings of their project to a wider audience, or for an extension of the work, ensuring a continual development of the methods and practice of PPI throughout the

country.

The winners will be announced at a ceremony which will form part of our Summer Conference.

Please visit our website for more details on the Awards, including submission criteria and how to enter.

**Organisations must submit their entries to reach the NCI by 5pm on Friday 15th May 2009.**

For further information, please contact **Freia Pagdin** -

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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 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 health-care 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.

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## *Round up of other news of interest*

*The Department of Health (DH) has issued the guidance 'Listening, responding, improving: a guide to better customer care' The information below has been taken from the DH website : [www.dh.gov.uk](http://www.dh.gov.uk)*

Health and social care staff strive to get things right but, if a mistake does happen, the important thing is to put things right and to use the experience to learn and improve.

The complaints system is being reformed because many problems take too long to resolve and services don't try to systematically learn from mistakes.

From the 1st April 2009, there will be a single approach to dealing with complaints. It will give organisations the flexibility they need to deal with complaints effectively. It will also encourage a culture that seeks and then uses people's experiences to make services more effective, personal and safe.

The guide 'Listening, Responding, Improving' has been developed to help complaints professionals work with colleagues to make their organisations better at listening, responding and learning from people's experiences.

It is designed to be accessible to anyone working in health and social care organisations who is involved in receiving feedback and resolving concerns and complaints from patients, service users and their representatives.

Additional advice sheets for complaints professionals have also been produced covering: investigating complaints, joint complaints that involve more than one organisation and dealing with serious complaints that have safety implications.

For news from AvMA please see the website: [www.avma.org.uk](http://www.avma.org.uk)