action against medical accidents

National Patient Safety Agency

Patients for Patient Safety Project Newsletter

November/ December 2009

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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

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

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

Or write or phone (details on the last page) to send in an item of interest or longer articles.

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

Go to 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.

Denmark PFPS Project Delegates Speak at Meeting in November

Helle Eckeroth

This meeting, the third national meeting of Champions and NHS Partners following on from the Induction Workshop that took place in May 2008, was held in London on 30th November.

Updates from Wales and each of the 10 SHA regions in England were provided in the delegate packs to inform participants about events and workstreams where champions had been, or were planned to be, involved.

Speakers included Martin Fletcher, Chief Executive NPSA, who proposed 10 areas where champions could get involved in the work of the NPSA. General discussion also took place about NPSA policies and Martin provided background to their planned activities. Emma Forbes from the NPSA extended project team, described the strengthening of the *Being open* policy and the recent events around the re-issue of the NPSA Alert for this.

Anna Allford, Project Manager, discussed the way in which the Formative Evaluation of the first year of the project had been conducted and the findings that had emerged. People involved in the project had responded to surveys and also given interviews that provided a narrative of their experience of being involved in the project. AvMA has made some recommendations in the report of the evaluation to inform the project. The report will be made available as soon as it is finalised.

International Speakers; Helle Eckeroth, Project Manager for the PFPS in-country project in Denmark, and Stine Elkjaer Larsen, a new Danish Champion, spoke about the way their project is working and Stine kindly shared her experience of being a patient. It was felt that there is much to learn from each other about the differences in the way the projects have developed but also it was agreed that there are some strong commonalties between the two.

Stine Elkjaer Larsen

One participant said "*I loved the Danish presentation and the insights they brought with them*."

Peter Walsh, Chief Executive of AvMA, led champions and NHS Partners in further discussions around the topics. Additional opportunities to discuss issues and concerns around patient safety with the project team had been built into the day. Importantly it was felt that looking forward to the future possibilities for partnership working, not only regionally/locally but nationally across agencies that have patient safety remits, is most valuable during these meetings.

The day was an exceptionally full one as always but much of the feedback has been about people reflecting on the role of champions and the way in which they can be involved in patient safety workstreams.

Connected programme

A member of the Wider Network discusses communication

'*Sticks and stones may break my bones, but words can never hurt me'* - yet the old adage does not hold true, particularly when it comes to healthcare. Poor communication can limit patient autonomy and choice; cause stress and psychological morbidity; lead to mistakes and the neglect of patients' needs. Communication issues are at the heart of many complaints and are an important, if often invisible, aspect of patient safety.

The good news is that communication is now recognised as a necessary core clinical skill, relevant to all specialties in health care. Research has shown that learned communication skills can not only enhance the patient/doctor consultation, but bring about behavioural and attitudinal changes which have a positive impact on psycho-social care and help ensure patients' needs are met.[1]

In accordance with the NHS Plan (2000) and NICE Supportive and Palliative Care Guidance (2004), a national programme for advanced communication skills training has now been developed, piloted and validated.

'Connected' is a robust, three-day programme incorporating the best of a number of previous programmes, designed to help clinicians recognise their own personal communication difficulties and develop new and different strategies to improve their communication skills.

Based on experiential learning, it uses actors and involves role-play and feed-back. Experienced facilitators have been trained to deliver the courses to Senior Health Care Professionals (SHCPs) through local Cancer Networks and the programme is managed by a team based within the National Cancer Action Team (NCAT), hosted by NHS London.

An Expert Reference Group, which includes two patient representatives, is responsible for the governance of the programme and will guide its future direction.

There is a Management Team, led by Rob Cockburn within NCAT, supported by 2 Clinical Leads. Zonal Advisers who were originally involved with the development of the programme, will liaise with Network Nurse Directors, Administrative Leads and others to provide ongoing support and guidance regarding many aspects of the course. The Facilitator's role is to deliver the programme (a minimum of 2 courses a year) and maintain their own competence, which includes being re-assessed every 5 years. The training and development of Facilitators, managed by the national team, will ensure that quality standards are maintained.

Although developed in cancer, pilot programmes have indicated that the core of the programme and its concept is transferable to other areas. Consequently, the vision is to develop and expand the Connected programme into other areas of both health and social care and to support the development of training programmes at other levels to encompass all staff.

Improved communication holds the promise of enhanced experiences for staff and patients, fewer complaints and greater safety for those on the receiving end of care.

Reference:

1 Jenkins V, Fallowfield L.

Can communication skills training alter physicians' beliefs and behaviour in clinics? Journal Clin Oncol;**20**: 765-9.

Mitzi Blennerhassett

Wider Network

We'd like to hear more about what other members of the Wider Network are involved in:

Are you a lay representative in health?

Do you have a project that you'd like to let other know about?

Have you attended any events around patient safety in healthcare that you want highlighted?

Tell us about your events and patient involvement

For further information please contact Anna Allford, Project Manager.
Email: **anna@avma.org.uk**

Or phone 020 8688 9555

International Summit on Open Disclosure

Embedding, enabling and aligning open disclosure across the world

I was invited by the NPSA to attend this summit on November 20th given by them and sponsored by the Commonwealth Fund. I was also accompanied by my colleague, Patients for Patient Safety Champion, Anne Carvalho.

The welcome and overview of the day was given by Martin Fletcher, Chief Executive of the NPSA.

This was followed by Plenary – 'Sorry seems to be the hardest word', given by James Conway, Vice President, Institute for Healthcare improvement, USA.

After this we heard perspectives from around the world on the subject: Is Healthcare to become more open?

Embedding open disclosure
Perspectives on embedding open disclosure within organisations
Chaired by Martin Fletcher, Chief Executive NPSA.

Rick Ledema, Professor and Director of the open disclosure within the Centre for Health Communication, University of organisations Technology Sydney, Australia.
Tim McDonald, Associate Chief Medical Director, University of Illinois Medical Centre, USA.

Enabling open disclosure
Perspectives on setting policy, developing appropriate support mechanisms and implementing open disclosure. Chaired by Steve Walker, Chief Executive, NHS Litigation Authority
Steve Kraman, Professor of Pulmonary, Critical Care and Sleep Medicine, University of Kentucky, USA
Gordon Wallace, Director of Education for Canadian Medical Protective Association and Associate Professor of Emergency Medicine at the University of Ottawa, Canada.

Aligning open disclosure
Perspectives that impact on staff, how best to support them and exploring malpractice and liability related issues

with implementing open disclosure.
Chaired by Steve Walker, Chief Executive, NHS Litigation Authority, UK
Marie Bismark, Senior Associate, Buddle Findlay, New Zealand
Dennis Boyle, Physician Risk Manager and Medical Director, COPIC Insurance, USA.

After lunch there, we were all organised into two Workstreams. I was in Workstream B. We discussed: How should organisations support staff and patients in being open when things go wrong?

We were to use the areas identified in the morning and explored how best organisations can support staff and patients in open disclosure.
Facilitators: Kate Beaumont, Head of NHS and Patient Engagement, Emma Forbes, Being open Lead, Sukhmeet Panesar, Clinical Advisor to Medical Director, NPSA.

This was followed by the merging of Worskstreams, which allowed us all an opportunity for structured reporting back on some of the key priorities and areas. Chaired by Wendy Levinson, Professor of Medicine and Chair of the Department of Medicine, University of Toronto, Canada.

Followed by **Being more open: patient and public perspectives**

Chaired by Martin Fletcher, Chief Executive of NPSA
How can we better involve patients and the community in our efforts?
How patients and the community can be included in open disclosure and reflecting on perspectives from WHO Patient Champions.
Peter Walsh, Chief Executive, AvMA and WHO Patient Safety Champion, UK.

Is the blame culture still a problem? Exploring the importance of an open and fair culture and reflecting on personal experience.
Martin Bromiley, pilot and Chair of Clinical Human Factors Group, UK.

To round up the summit we heard from Albert Wu, Professor of Public Health, Johns Hopkins University, USA with a summary of the day, consensus and learning points.

On this day, many words were spoken by all delegates about open disclosure and telling the truth, but the ones that stay with me are

"Errors do not erode trust. The way we act afterwards, does. The consequences of failure to disclose, to say I am sorry, to apologize, are devastating. There is no greater value than respect, and governance and leadership set the culture".

Peter Metherall
Patients for Patient Safety Champion

More information can be found at:

www.nrls.npsa.nhs.uk

Formative Evaluation Report of the first 12 months of the PfPS Project

Passionate about safety

The evaluation is largely qualitative focusing on obtaining the views of; Patients for Patient Safety (PfPS) Champions and their NHS Partners, the project team, plus the project's Strategic Advisory Group, and PfPS network members, to explore the project in its first year from their perspective.

Using illustrations from the interviews and surveys undertaken as part of the evaluation together with examples of partnership working demonstrating the type of involvement and levels achieved in some regions, the report outlines; achievements and learning, challenges and opportunities, and formative issues for the management of the project. It also reflects on the role of: the Champions and their NHS partners; AvMA; and the Project Manager. Views were also sought on the future direction of the project and this is discussed with conclusions and recommendations drawn from these.

Outcomes to date

Over the year since the induction workshop there has been good progress in developing the project overall. In at least three areas the success of the champions in bringing patient perspectives to local work on patient safety has already been truly excellent and inspiring. Evidence of passion towards improving patient safety was clear amongst those interviewed and from the survey and it was felt by PfPS Champions, NHS partners, and PfPS network members that the project sought to utilize this emotional connection to inspire others. A stakeholder commented that their reason for being involved in the project is 'because I was passionate and committed to raising awareness and ensuring that patient safety was a priority.'

Importantly it was felt by a PfPS network member that raising the profile of the need to prioritise patient safety is tangible within the project

"At last the patients and their safety is taking a centre place in the treatment of patients."

Patient stories about their experience are seen to be of real value providing an opportunity to engage healthcare professionals using examples they can relate to. Many PfPS Champions have developed their style of presenting their story during the project.

"there is great value in the patient's story and that will have much greater impact than any policy."
Strategic Advisory Group member

Measuring change in culture around patient safety was felt to be not just about quantitative measurements that related to statistics but more about attitudes and how this reflected on care, being open when things go wrong and a readiness to change and adapt appropriately to make NHS care safer. It was agreed more qualitative measures needed to be developed as tools for this. Interestingly, one PfPS Champion highlighted the need to consider further which groups the change is being measured for; clinicians, managers, or patients?

"*measuring change also depends on who you're looking at, are you looking at it through the eyes of the patient, in which case certain things will affect the improvement and other things won't, if you're looking at it from a clinician, they are seeing it through completely different eyes so when you're measuring change and you decide whose eyes is the change coming about or who are you trying to measure it for* "

A PfPS network member summed up the way they felt healthcare professionals could change the culture:

Sometimes it makes me feel very strong and makes me feel that along with all these other people who are backing me and all these other people who are working with me and all these other people who are doing the same things…I can make a difference.
PfPS Champion

"To be open to criticism, be patient friendly and not wrapped up in professionalism with the attitude that lay people are not educated enough in medical issues to make effective contribution."

PfPS Champions & NHS Partners

The project as currently designed and resourced has been successful in establishing the network of patient safety champions and has been able to provide them and their NHS Partners with support and where appropriate training. Basic facilitation and development of the 'PfPS network' has also been possible, but the project is not resourced to do more than service and support the existing champions and their relationship with NHS Partners. The aim of the project is to provide a platform for PfPS Champions to have real opportunities to be the patients' voice in current and planned improvements in patient safety and also to promote patient involvement and engagement in this area.

"I'm in a strong position but it's only because of the role of the Patient Champion where I'm in a position where I could do that "
PfPS Champion

Anna Allford

Project Manager PfPS England and Wales

HSJ Awards 2009

Held at the Grosvenor House Hotel, London. 30th November

I was invited by the NPSA to attend this awards ceremony given by the Health Service Journal. The evening was compèred by James Nesbitt (actor of Cold Feet and Murphy's Law fame).

The Awards Ceremony took over three and a half hours because there were 18 categories and 1000 entrants!

There was a wide range of awards, all setting the standards for the coming year. The following is a small sample.

- Acute Health Organisation of the Year went to Royal Bournemouth and Christchurch Hospitals Foundation Trust.
- Primary Care Organisation of the Year was won by Liverpool PCT (Primary Care Trust).
- Patient Centred Care was awarded to NHS South Tyne and Wear.
- NPSA Award for Patient Safety was won by the London Deanery.

This important national award recognises services that demonstrate Patient Safety as being at the heart of an organisational culture. London Deanery's Head of Innovation said "*London Deanery is committed to provide the best possible education for doctors in training. A high quality work force requires high quality education. Our world-leading simulation technology and advanced educational techniques highlight Patient Safety, and promote clinical excellence.*

Research on simulation has shown that trainees who develop their skills on simulators learn faster and make fewer errors than those who do not. We are delighted that our innovative approach to healthcare training has been recognised".

The awards finished at around 11.30pm. They were followed by dancing and a gambling casino where everyone bought $100 worth of tokens for £10 and all proceeds were given to the HSJ's charity for this year, Macmillan Nurses. As you can imagine, with the large numbers of people present a great deal of money was raised, and a lot of talk talked, mainly about medical matters. Carriages were at 2am!

I thank Martin Fletcher for inviting me, and also Clare Abberton and Kate Beaumont of the NPSA, who were my lovely 'minders' for a most enjoyable evening.

Peter Metherall
Patient for Patient Safety Champion

Care Quality Commission (CQC)

New guidance launched for providers on meeting quality and safety standards

The guidance focuses on outcomes - the experiences people have as a result of the care they receive - rather than on systems and processes. It consists of a Summary of regulations and outcomes that comprise the Essential standards and Judgement framework; Essential standards of quality and safety that make clear the outcomes CQC expects and the Judgement framework which CQC inspectors will use to judge compliance.

The following extract is from the CQC website:

How do providers make sure they comply with the new regulations?
To register with us, providers must demonstrate they meet the new essential standards of quality and safety across all the services they provide.

By law, we are required to produce guidance about compliance with the new regulations. The guidance applies to all health and adult social care providers. It describes quality and safety from the perspective of people who use services and places them at the centre of the registration system. The guidance focusses on people rather than policies, on outcomes rather than systems. It relates to important aspects of care such as:

- involvement and information
- personalised care and treatment
- safety and safeguarding

For further details visit the CQC website:

www.cqc.org.uk

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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.

Round up of other news of interest

Royal College of Anaesthetists

Workshops announced for newly launched anaesthesia incident reporting portal

The Anaesthetic eForm was launched on 30th of November and is a portal to report any anaesthesia related untoward incidents for review and learning. A series of workshops will commence in January to orientate practitioners in the use of the portal.

Medical Protection Society

Survey suggests working time directive having adverse impact on surgical training

The survey of over 1,600 surgeons-in-training from all specialties, found that two-thirds felt that the quality of training they received had worsened since the introduction of a working hours limit and a similar figure (67%) reported that they stay at work beyond their official working hours to ensure they receive enough training.

General Medical Council

GMC study calls for standardised prescription chart to reduce prescribing errors

The study looked at 124,260 medication orders across 19 hospitals and found that 11,077 contained errors, an error rate of 8.9% and potentially lethal errors were found in fewer than 2% of erroneous prescriptions; 40% of the all orders were made by foundation year junior doctors. The report recommends the introduction of a standardised prescription chart and improvements to medical education.

For news from AvMA please see the website: **ww.avma.org.uk**