avma
action against medical accidents

NHS
National Patient Safety Agency

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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

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.

Associate Patient Safety Champion
For East Midlands region

We are delighted to welcome Amanda Pearce to the project as a new Associate Patient Safety Champion.

Amanda has filled the vacancy in the East Midlands region and will be working in partnership with Wendy Martin and other members of the Patient Safety Action Team for the Strategic Health Authority (SHA) in the region.

Joining the existing Patients for Patient Safety Champion, Gillian Bean, she will work locally, regionally and nationally, providing the patient perspective around patient safety improvement work in the NHS.

Amanda says, *"Due to a congenital condition I spent a lot of my teenage years gaining patient experience of primary, acute and tertiary services in the NHS. This experience as a whole has been good. I have received quick, good quality treatment as and when required. However there have been a number of incidents over the years where near misses and mistakes have occurred. Most of these have been minor and in most instances the mistakes were quickly rectified and I received swift apologises from the medical professionals involved."*

Amanda continues; *"During one such incident, I had to undergo two corrective surgeries and spend an extra three weeks in hospital after mistakes were made during an emergency procedure. I received a full apology from the consultant in charge and from the surgeon who made the mistakes.*

As a consequence of the incident the surgeon received additional training and mentoring to enable him to learn from his mistake. Though traumatic at the time I am happy with the way the incident was dealt with. The mistake was quickly rectified resulting in no lasting damage to myself, the apology came quickly and steps were taken to ensure that all of the staff involved were able to learn from the mistake."

Amanda has already met with Anna Allford, Project Manager, and Wendy to discuss her role and how her experiences can help NHS bodies and their staff to understand better the ways in which patient views can add value to current and future workstreams around patient safety improvements.

In early August Amanda joined a Workshop to discuss a new leaflet being designed by the National Patient Safety Agency and NHS Confederation which will help Local Involvement Networks (LINks) and Foundation Trust Lay Governors ask key questions around patient safety. Amanda contributed towards the development of the national leaflet and we hope that a more wider discussion will take place once a draft version is available.

Amanda adds; *"I believe that in general the NHS is run safely but it is not perfect and there is much room for improvement of patient safety. I have become involved in this project so that I may improve and give something back to the service which has done so much for me and continues to do so."*

Could you be an Associate Patient Safety Champion ?

We have a vacancy in the West Midlands for this voluntary role

We are looking for existing or potential patients – especially those who have experienced things going wrong – who are prepared to volunteer a little of their time to work with NHS staff to help improve patient safety.

Following a recruitment exercise in 2008 the project, a unique partnership between the NHS National Patient Safety Agency and the charity Action Against Medical Accidents, held an Induction Workshop for 22 volunteer Patients for Patient Safety "Champions". They have been working with each of the Patient Safety Action Teams of the Strategic Health Authorities (SHAs) in England and the Patient Safety Manager in Wales. The role of the 'champions' is to champion the cause of patient safety and the role that patients can play in patient safety work. They provide a patient perspective in the planning of patient safety work in their region and get involved in specific projects where they can make a useful contribution.

Specifically this role is to recruit a volunteer Associate Champion to work in partnership with the West Midland's Patient Safety Action Team. Regional work will be based around one of the 3 areas of the West Midlands Strategic Health Authority region. The Associate Champion would be required to represent the interests of the area in which they are resident within this SHA region.

As there are 2 Champions to each SHA region in England and the existing Patient Safety Champion is resident in the Birmingham area, the Associate Champion will be resident in Worcester, Herefordshire, Coventry, Warwickshire, or in the Shropshire/Staffordshire area.

More details about the project and the work of Champions can be found on the AvMA website: **www.avma.org.uk/champions**

If you feel you have a passion for patient safety please ensure you have read the Role Description for Associate Patient Safety Champions together with the Selection Criteria for Champions plus the London Declaration and complete an Expression of Interest form that should be returned to:

Anna Allford, Project Manager,

Patients for Patient Safety, AvMA, 44 High Street, Croydon CR0 1YB

or by e-mail to: safety@avma.org.uk by 9am on 4th September 2009

If you require further information about the role please contact: Anna Allford, Patients for Patient Safety Project Manager, at AvMA, on 020 8688 9555;

or Aly Hulme, NHS West Midlands Patient Safety Manager- Patient Safety Action Team on 0121 695 2592

Wider Involvement Network

Thank you to those members of the Network who responded to the recent survey. The Evaluation report will be drafted in the next month and will be available later this year.

We are conscious that many of you want to be more actively involved in the project and would love to hear your ideas on how this can be achieved.

Social Movements

The project would like to develop the Wider Network to become a 'social movement'.

A social movement can be defined as:

A voluntary collective of individuals committed to promoting or resisting change through co-ordinated activity. [1]

Tell us your ideas on how you want to be more involved and how you think we can build up this Network to create a social movement

In health in particular, this is an important aspect of how patients and the public can work in partnership with healthcare professionals to help in patient safety improvement work.

The project's aim is to increase the number of people belonging to the Wider Network. Please invite friends and colleagues to be part of this social movement.

To join and for further information please contact Anna Allford, Project Manager. Email: **anna@avma.org.uk**

Reference: [1] *The Power of One, The Power of Many,* Jo Bibby, Helen Bevan, Elizabeth Carter, Prof Paul Bate, Glenn Robert. NHS Institute for Innovation and Improvement, 2009

Patient Safety Champion joins 'Matching Michigan' project External Reference Group

Stuart Stevenson, PfPS Champion in Wales, was invited to join the national External Reference Group for the Matching Michigan project. Stuart writes about the project here after attending his first meeting.

An estimated 200,000 central venous catheters (CVCs) are inserted in UK each year. Of these, approximately 6.2% (or 12,400 cases) may be associated with blood stream infections (BSIs). The report "High Quality Care for All: NHS Next Stage Review" recommended a national patient safety initiative to reduce CVC associated bloodstream infections (CABSIs) titled 'Matching Michigan'. This initiative draws on evidence from a study conducted by Professor Peter Pronovost and his colleagues in intensive care units (ICUs) in Michigan, USA.

This study was published in the New England Journal of Medicine in 2006 and showed that evidence-based interventions resulted in a large and sustained reduction (up to 66%) in rates of CABSIs that was maintained throughout 18 months. Although Wales & Scotland have made progress in the area, the UK as a whole lacks a standardised reporting system for blood stream infections attributable to CVCs. This impedes benchmarking, feedback of data to clinicians, and nationwide improvement efforts.

Aims and objectives.

- Provide clinicians & hospitals with web-based data collection & reporting system for CABSI rates in ICUs in England.
- Minimise CABSIs in adult & paediatric ICUs in England by supporting best practice guidance and offering additional behaviour change interventions.
- Enhance overall patient safety by promoting technical and adaptive (cultural) interventions in ICUs.
- Spread the interventions to other clinical areas which use CVCs.

This is a two year project involving all adult and paediatric ICUs in England.

There have been several campaigns in the UK over the last few years to tackle central-line catheter related bloodstream infections. These include the Department of Healths 'High Impact Interventions' (HIIs) and the Patient Safety First Campaign. Considerable time and resource have gone in to developing these initiatives and therefore Matching Michigan will build on their achievements.

NATIONAL PATIENT SAFETY AGENCY
Catheter-Associated Bloodstream Infection Minimisation Project: Matching Michigan
External Reference Group
Terms of Reference

1. To act as a source of knowledge and expertise to aid the NPSA in taking forward the Matching Michigan development.
2. Provide support, guidance and advice on the broad range of issues relating to intensive care medicine, infection control and quality improvement/research methodologies.
3. To endorse the initiative, when appropriate.
4. Advise on most appropriate methods of communication and dissemination of initiatives and best practice and encourage stakeholder engagement.
5. Disseminate agreed information to members of their organisation on behalf of the NPSA
6. Review the implementation/project plans and processes, provide advice when problems arise, identify and develop specific solutions which can be implemented in ICUs within England.
7. Ensure that the service user and patient perspective is appropriately addressed.
8. Ensure that all relevant stakeholders are involved in and kept informed of this project.
9. Provide advice on data

Stuart will attend the next meeting in November.

* Information/ references taken directly from;

Revision of the Department of Health's 'High Impact Intervention' no 1 central venous care bundle matching Michigan May 2009.

National Patient Safety Agency national reporting and learning service. Minimising central venous catheter associated bloodstream infections; Matching Michigan. April 2009.

National Patient Safety Agency (NPSA) Catheter Associated Bloodstream Infection Minimisation Project. Matching Michigan External Reference Group Terms of Reference.

Being open, NPSA Policy Re-launch

As the National Patient Safety Agency (NPSA) develop their plans for strengthening the *Being open* policy (communicating patient safety incidents with patients and their carers) and processes, Patient Safety Champions have been invited to get involved.

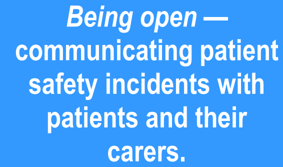
The *Being open* policy advises healthcare staff to apologise to patients, their families or carers if a mistake or error is made that leads to moderate or severe harm or death, explain clearly what went wrong and what will be done to stop the problem happening again.

Two Champions have been invited to attend each of the 3 Workshops that are planned in September. The NPSA is hosting the meetings during 'Patient Safety First' week. The following themes will be explored:

- **Strengthening *Being open* – the role of PALS, CHCs and ICAS.**
- **Strengthening *Being open* – the role of Boards .**
- **Strengthening *Being open* – the role of *Being open* experts**

The workshops will focus on developing the relevant role in relation to *Being open* as well as review amendments to the *Being open* policy document (to update it in light of *High Quality Care for All*). They will also explore what additional support and guidance will be required to assist with implementation by organisations.

Additionally, four Champions together with Anna Allford, Project Manager and Emma Forbes, the NPSA Lead for *Being open*, will form a Working Group to look at how Champions can discuss with and support NHS organisations locally and regionally. Working Group members will canvass opinion of the Champions and agree how to take forward plans following the re-launch later this year.



More information about *Being open* can be found on the NPSA website:

www.npsa.nhs.uk

Department of Health Consultations

Department of Health (DH) consults on de-authorisation of NHS Foundation Trusts

Following the failings at Mid Staffordshire Foundation Trust, the Government is consulting on whether to confer Monitor and the Secretary of State for Health, powers to be able to de-authorise poor performing Foundation Trusts.

Closing date is 18 September.

More information can be found at the website address below:

http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_103359

New Horizons: towards a shared vision for mental health—consultation

New Horizons: towards a shared vision for mental health sets out ways of achieving a transformation in mental health care by targeting root causes of mental illness, earlier intervention and developing higher quality, more personalised care. It also explores how services can become more innovative and work better together.

Closing date is 15 October.

More information can be found at the website address below:

http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_103144

NICE starts work on setting quality standards

The National Institute for Health and Clinical Excellence (NICE) welcomes the referral of four clinical areas by the Department of Health following advice from the National Quality Board and will now begin work on setting NICE quality standards for the NHS using a pilot process.

The Darzi report, High Quality Care For All (June 2008), expanded NICE's role to include setting and approving more independent quality standards for the NHS. The report highlighted the difficulties clinicians faced in keeping up with the best evidence. It stated that standards should clarify what high quality care looks like with regard to:

- clinical effectiveness
- patient safety
- patient experience.

This work is a key part of making quality the organising principle of the NHS and supporting the drive to improve standards of care.

NICE quality standards are a set of specific, concise statements which act as markers of high quality, cost effective care across a pathway or a clinical area. They are derived from the best available evidence and are to be produced by NICE in collaboration with the NHS and social care, along with their partners and service users, for use by clinicians, patients, service providers and commissioners. The statements in each NICE quality standard will be accompanied by a measurable element or indicator in order to enable an assessment of quality and quality improvement to be made.

The National Quality Board has referred the following clinical areas for NICE quality standards to be developed:

- Stroke
- Dementia
- Neonatal Care
- Venous Thromboembolism (VTE)

NICE quality standards are to be developed by a group of relevant clinical and public health experts, appropriate professional groups and generalists (including commissioners), and lay representatives who will form time-limited Topic Expert Groups (TEGs). Draft NICE quality standards will be based on relevant evidence and formalised by the TEGs who are to consider the cost impact of the standards to the NHS before consulting and field testing the statements prior to final publication.

Where the topic referrals identify a clear social care or preventive interface these aspects can be included in the quality standards.

NICE has established a pilot process to develop its first quality standards and plans to consult on the ongoing development process later this summer. The first NICE quality standards developed from the pilot process are expected to be published in early 2010.

Val Moore, NICE Implementation Director said: "Quality is at the heart of the care delivered by all parts of the NHS and this is an exciting opportunity for NICE to set the standards by which this quality can be measured. We have set out an interim process to develop the NICE quality standards which will draw on expertise from clinical and public health experts, Royal Colleges and Specialist Societies, lay members, commissioners and service providers. NICE will also consult on and field test the draft standards before publishing them. We expect that the first NICE quality standards developed from the pilot process to be available in early 2010."

Bruce Keogh, NHS Medical Director said: "The quality standards that are being developed by NICE will give patients and NHS and Social Care staff absolute clarity on what high quality care in these four areas looks like. They will set the course for the development of a library of quality standards."

Academy of Medical Royal Colleges (AOMRC) publishes draft curriculum for graduate doctors

This draft document describes the competences for Foundation level 1 and 2 doctors (F1 & F2). It also sets out how these will be assessed.

Of particular interest might be section 7 '***Patient Safety within Clinical Governance'*** with it's subsections as follows:

i) Treats the patient as the centre of care

ii) Makes patient safety a priority in own clinical practice

iii) Promotes patient safety through good team-working

iv) Understands the principles of quality and safety improvements

v) Complaints.

More details of this section and the full document can be found at:

/www.aomrc.org.uk/aomrc/admin/news/docs/Draft%20Foundation%20Programme%20Curriculum%20for%20review.pdf

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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

Summary of Coroners' Reports into avoidable deaths is published

Rule changes in July 2008 allowed coroners to write detailed reports following inquests that revealed a risk of more deaths occurring, including suggesting what action should be taken to prevent future deaths. The first annual summary of these reports underlines the need for better hospital communication processes.

More information can be found at the website:

http://www.justice.gov.uk/publications/docs/rule-43-bulletin-06-07-2009-web.pdf

Governance arrangements to support PCT provider committees

Provider Committees need to focus on quality, taking into account patient safety, patient experience and effective outcomes. This guidance will help to ensure that these committees are able to independently monitor, identify and mitigate risks to patients.

More information can be found at the website:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_103454

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