

Patients for Patient Safety Project Newsletter

Volume 2, Issue 3

March 2009

National Patient Safety Agency

Project is presented at International Congress in Turkey

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 project and some of the ways in which Champions have been involved in local, regional or national work. Plus items of national interest 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 article.

Anna Allford, Project Manager, was invited to speak at the International Health Performance and Quality Congress taking place in Antalya, Turkey, between March 19th-21st.

This Conference was organised by the Ministry of Health of Turkey and they kindly paid my expenses so I took a couple of days annual leave and flew out. The flights there and back took the best part of a day as I had to change at Istanbul. This gave me time to look more at the geography of this huge country, bordered by Syria, Iraq, Iran, Armenia and Georgia. Turkey has always been an important area with regard to strategic ports and shipping lanes and this is reflected in its rich and chequered history.

I was just as much interested to learn more about how they organise healthcare across this vast country as I was keen to tell them all about our project and the types of work Patient Safety Champions and the Wider Network have already been involved in since their inception almost a year ago.

I arrived for the second day of the Conference on Friday and was scheduled to give my presentation on Saturday morning. I was told that as many as 1300 participants were registered in total and the Conference was spread over 3 parallel meeting rooms. The main room had translation into English through headphones as the Speakers gave their talks so I could only attend sessions in that room.

Healthcare professionals and policy makers from Turkey, USA, England and representatives of the World Health Organization discussed the main theme which was the 'Promotion of Staff and Patient Safety' (their translation). Various topics included:

- ◆ Patient Safety Implementations from Theory to Practice; and
- ◆ International Tendencies in Quality and Patient Safety.

Turkey has a similar Social Security system to cover the cost of public healthcare for citizens and there is a mixture of private care hospitals too. They aim to have a set of 'Standard Operating Procedures' in order to provide standardised care no matter wherever anyone should live. I understood this to be comparable to our system of 'Patient Care Pathways'. There were concerns that sometimes independent decisions by clinicians to order tests or perform procedures could be hampered by what the Ministry of Health define required for specific conditions but this system would also ensure that access to appropriate treatment is more equitable — a fine balance that many healthcare systems have to work towards achieving.

I was delighted to be first Speaker on the morning of the 21st and gave a presentation about the project, the role of the Champions plus some of the work to date, and with how we wish to develop the Wider Network. I also told delegates that we have discovered that in many areas there is a need for more Champions. The project is looking to develop a model that helps facilitate 'Associate' Patient Safety Champions locally to support current Champions. We are currently discussing the way forward with the project team to ensure we have things in place before advertising for these new roles.

The presentation can be found on the AvMA website: www.avma.org.uk/champions

Anna Allford, Project Manager

Stop Press!

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.

- ◆ New Roles and Experiences in Patient Safety;
- ◆ Reflections of Patient Safety and Patient Satisfaction;

ALL PARTY PARLIAMENTARY GROUP ON PATIENT SAFETY

Portcullis House, London, 10th March

Dr. Howard Stoute – Group Chair – introduced the meeting by stressing the importance of patient safety. He also welcomed members of the Health Foundation who have taken over responsibility for supporting the Group from Baxter Healthcare. The meeting itself was designed to facilitate discussion on themes which will shape the focus of future meetings with respect patient safety. The three speakers were then introduced:

Stephen Thornton – Chief Executive Officer, The Health Foundation.

Outlined the background to developments in patient safety over the last 10 years and looked forward possible developments in the forthcoming financial year. The Health Foundation has invested heavily in the Safer Patients Initiative (SPI) which is operating in 20 hospitals. Reference was also made to the creation of the NPSA and the National Learning Reporting System which receives in excess of 850,000 reports of adverse incidents per annum. His belief is that there should be a focus on “building enthusiasm” amongst clinicians and hospital staff and social care providers in respect of patient safety. He stressed the importance of “measurement” not only in respect of patient outcomes but in relation to personal performance. There was some support for the culture of openness but stressed that this could also lead to fractious relationships between clinicians and patients.

Dr. Peter Cavanagh – Consultant Radiologist Taunton & Somerset NHS Trust and Advisor to NHS South West on Patient Safety

Outlined a typical patient experience which had taken place in Taunton and some of the lessons that might be learnt. Firmly believed that safety should be the product of the system which

- should have reliable measurement processes in place to determine

improvement outcomes

- there should be continuity of care relating to transfer of patients between wards and between provider organizations
 - there must be strong leadership at all levels
- ⇒ provision of “will” should be provide by the CEO and any attitude adopted that any infection is unacceptable
- ⇒ good practice from different organizations should be adopted
- ⇒ there should be a focus on the identification of measurable improvement
- ⇒ there should be collaboration between healthcare professionals to establish best practice for patients.

Lesley Bentley – Chair Patient Liaison Group for Royal College of Surgeons

Support the establishment of a culture of critical incident reporting but emphasized the conflicts of interest between targets and patient requirements. The culture of openness needs to be embedded within the NHS but there needs to more progress towards implementation of the lessons to be learnt and the necessity for the Care Quality Commission to drive up standards of care. She expressed concern as to the “blurring of boundaries” between the roles of clinicians and the enforcement of the 48 hour week for junior doctors from August 2009.

A discussion then took place with 30 or so delegates present, although only 5 contributed to the debate. Margaret Dangoor, Executive Director of Litigation and Risk Management, made several points relating to collaboration between consultants and that improved systems do contribute to patients’ safety. A former airline pilot (Guy Hurst) now operating a training company for NHS Staff alluded to the

lack of consistent information for staff and culture of denial which exists within some NHS Trusts. I made the point that patient safety and efficiency are one and the same. Improvements in patient safety equal reductions in costs. It was necessity to introduce short term investment in order to accumulate efficiency savings into the future. (e.g. electronic prescribing)

The point was also made that patient empowerment, involvement and engagement was crucial to the development of modern healthcare. Patients and their carers are the experts on their own feelings and symptoms and to a large degree should be experts in their own care.

Disappointingly the CEO Health Foundation stressed that informed patients could be viewed as threatening by clinicians who needed to maintain complete control of their environment.

Meeting concluded 18.30 and the comments made will be taken into account when deciding the future direction of the All Party Group.

Graham Tanner,
Patient Safety Champion

Update on Champions and NHS Partners in England and Wales

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 for South East Coast SHA, met with their new SHA Partner, Alison Walton, together with Anna Allford, Project Manager, to discuss ways forward on Being Open. The Champions are reviewing the policies of all Trusts in their region to look at how Being Open is being implemented and evaluated. Plus they want to know how this policy in practice has improved things for patients/families when things go wrong.
- Simon Mathias, Champion in the South West, gave a presentation at an event in Exeter for Non-Executive Directors and Chief Executives. Anna Allford also presented the project that day and Simon ensured that the patient perspective, particularly around Being Open was included in the event. Graham Tanner has been helping Gloucester Hospitals NHS Foundation Trust with their proposed research project on patient safety and Graham and Anna plan to meet with the Director of Patient Safety together in the near future.
- Marlene Moura and Peter Metherall, Champions in East of England (E of E), attended the E of E Patients Safety Clinical Programme Board on 4th March. The latest update on the HCAI Taskforce, National Campaign, is that all of the E of E Trusts are signed up. There is a conference planned for June on *Never Events*.
- In London, Champions, Jenni Dewhurst and Val Baker, have been contacted by several organisations to involve them in their plans for patient safety improvement work.
- Stuart Stevenson, Champion, continues to give talks and offer his help and advice both locally and nationally in Wales. Meryl Davies the other Champion for Wales is hoping to make contact with her local Trust to find out more about their policy around Being Open.
- In East Midlands, Champions Gillian Bean, has been busy attending events and representing Champions at a national level as the remaining Champion vacancy has led the SHA to consider more 'Associate' Champion roles could be developed to ensure all 5 counties have patient representation at a strategic level.
- South Central SHA have continued to include Champions, Anne Carvalho and Chista Kermani, in their core workstreams around patient safety.
- NHS Yorkshire and the Humber have offered opportunities for involvement to both Iain Wordsworth and Narendra Mathur, Champions, in the area. They will share out some of the meetings between them but continue to work together on others. This way they can maximize their time and efforts to ensure the patients' voice is included.
- In the North East Champions, Margaret Ogden and Mike Casselden have had a slightly reduced involvement due to health and work commitments but a Conference is planned in June to which the Champions will be invited and Anna will also be presenting the project.
- Beryl Nock, Champion in West Midlands, visited the Campaign office of the Patient Support Group 'CuretheNHS' in Stafford, with Peter Walsh, AvMA's Chief Executive, and Anna Allford. This group was created by people who have lost relatives or were victims of poor care and support within mid Staffordshire Foundation trust Hospitals at Stafford and Cannock. Beryl will be in contact with them and liaise with the SHA to let them know of the concerns over current care.

Read more about AvMA's partnership with the Support Group and the Healthcare Commission's report on care at Mid Staffordshire NHS Foundation Trust on page 5.

Wider Involvement Network

The project is keen to hear from people in the Wider Network who would be interested in supporting the work of the current Patient Safety Champions in the East Midlands and West Midlands areas.

We are proposing that 'Associate' Patient Safety Champions could help Champions with their workload by attending meetings or even giving talks. They would be volunteers within the project but could be facilitated by the project, for example, by providing information and where possible some training and development.

Would you be interested in becoming an 'Associate' Patient Safety Champion?

We have not put together a recruitment pack for these positions yet but we thought we would flag up this new development to give you time to think if you'd like to get involved.

We'll send out further information once we have agreed everything with the project team. In the meantime if you are interested please do contact Anna Allford, Project Manager at the address on the last page.

Patient safety partnership Northwest

Last November at the patient safety champions meeting I think Ann Bisbrown-Lee summed up our partnership with SHA Northwest brilliantly in the one sentence: **'its working and its working brilliantly'**. We both think the reason for that is because we have the right ingredients. The Patient Safety Action Team (PSAT) are committed and passionate and truly want to make this work and that's the attitude Ann and I have.

The last few weeks sadly Ann has been looking after her Mum who contracted Clostridium Difficile in hospital in January. But our inclusion has still been foremost in the Northwest PSAT.

Currently and over the last few weeks partnership working has included:

- Working on an ongoing action framework plan to give clear precise information for patients and the public on patient safety issues, following the National Patient Safety Agency (NPSA) publishing their patient safety incidents.

- Ann has been invited on to the project for Child services

- Bev was invited to be on the PDEMSA (Privacy & Dignity Eliminating Mixed Sex Accommodation) project team committee. There are weekly development meetings as the deadline is set for June to have compliance action plans in place

- Bev was part of the SHA team on

the Department of Health ' Hypothesis Testing Trust Visit: this involved a full day working with the Hospital Team, DH team, PCT team. Interviews were held with: Chief Executive; Nursing Directors; Clinicians; Associate Directors; Estates; and there was also walkabouts within different areas of the Hospital. The Northwest was the first in a series of 6 fact finding inspections taking place nationwide and the work that was done will help evaluate how to take forward the project plans. The Dept of Health were delighted to have a patient perspective on the day and took forward some comments made for their next planned visits which will happen over the next 10 days.

- We are currently working with the Care Indicators group for metrics for the care indicators for nurses

- Through the Health Care Associated Infection (HCAI) Implementation lead we have now been contacted by the Improvement foundation who has asked for a meeting to undertake work around the region for care homes

- Other work involved has been with Trusts and PCTs around the region who are also committed and keen to promote the work of the patient safety champions

- We have also been asked to look at mental health issues with the lead on mental health

- Bev has been appointed a role on the first ever PFPS global HCAI working group and has been invited to take part in the two day technical event leading to the launch of the **Save Lives: Clean your Hands** campaign.

The two day event takes place in Geneva 4 – 5 May this year

- Bev and Ann will be attending the Patient Safety Congress 30 April/1 May: thanks to sponsorship by Salford Royal NHS Foundation Trust: Bev is speaking at the congress along with Patient Safety Champion Anne Carvalho (South Central) so although the Congress give free passes on the day to speakers, Salford offered to sponsor Bev and Ann to allow them to attend the other day.

Not only is this work all happening individually, Ann is involved with Sefton PCT, governance, safety and care quality committees, is a member of Sefton LINKs and is also a QOF lay assessor. Bev speaks at a number of national conferences on not only Healthcare Infections but other patient safety issues. Is a patient consultant on a number of research funded projects, and is also the administrator for NCHI which involves regularly giving advice and support to families who require it and meetings with the DH and other healthcare agencies/bodies.

Bev Hurst,

Patient Safety Champion

Care Quality Commission

The Health Care Commission no longer exists and many of it's functions have been transferred to the Care Quality Commission (CQC). The statement below is taken from their website www.cqc.org.uk

There is also a video explaining what the Care Quality Commission aims to achieve on their website.

The Care Quality Commission is the independent regulator of health and social care in England. Our aim is to make sure better care is provided for everyone, whether that's in hospital, in care homes, in people's own homes, or elsewhere. We regulate health and adult social care services, whether provided by the NHS, local authorities, private companies or voluntary organisations. And, we protect the rights of people detained under the Mental Health Act.

CALL FOR PUBLIC INQUIRY OVER MID STAFFORDSHIRE

Action against Medical Accidents (AvMA) – the charity for patient safety and justice, has written to Alan Johnson the Secretary of State for Health asking for a public inquiry into how the Mid Staffordshire Hospital scandal was allowed to happen, and offering to help with the independent review of medical records promised to patients and families.

In an open letter to Mr Johnson, AvMA say that the Healthcare Commission report does not go far enough. What is needed is an examination of how existing systems for monitoring and regulating patient safety failed so spectacularly and tragically. AvMA also thank Mr Johnson for the offer he made on national TV to guarantee any concerned patient or family with concerns about treatment at Mid Staffordshire NHS Trust to have an independent review of their medical records. AvMA is offering to advise the Department of Health on how this can best be conducted and to offer independent advice and support to concerned patients and families from AvMA's trained staff and volunteers.

In a report published on 17th March the Health Care Commission criticised Mid Staffordshire NHS Foundation Trust for significant failings in emergency health-care, leadership and management. The report states that there were deficiencies at "virtually every stage" in

the care of people admitted as emergencies.

The Commission launched its investigation at the trust in March 2008 in response to concerns from local people and when it became clear that the trust stood out statistically in terms of the high death rates of patients admitted as emergencies. The Commission regularly scans rates of mortality in trusts across England and became aware of an unprecedented 11 occasions when the trust's performance deviated statistically from what would have been expected between July 2007 and November 2008. The statistical analysis served as a trigger - it raised questions which the investigation sought to answer.

Sir Ian Kennedy, the Commission's Chairman, said: "This is a story of appalling standards of care and chaotic systems for looking after patients. There were inadequacies at almost every stage in the care of emergency patients. There is no doubt that patients will have suffered and some of them will have died as a result. The investigation found there were too few doctors and nurses, vital equipment was not available when needed, patients did not receive the care they deserved, and the trust had no systems in place to spot when things were going wrong..." He added: "Trusts must always put the safety of patients first. Targets or an application for foundation

trust status do not lessen a board's responsibility to its patients' safety. We look regularly at rates of mortality across the NHS. Any concerns such as those at Mid Staffs would be acted upon swiftly."

Peter Walsh met with members of the Patient Support Group CureTheNHS together with Champion, Beryl Nock and Anna Allford, Project Manager. AvMA has offered its support and to work in partnership with the group. In addition to calling for a public inquiry there will be some face to face sessions made available by AvMA's Medico-Legal Advisory staff to local people who think they or their families may have been affected. AvMA leaflets and the help-line phone number will also be distributed to people who contact the Support Group or call into the 'Breaks Café' which has become the focal meeting point for people wanting information.

Further information about the Support group can be obtained from their website:

www.curethenhs.co.uk

Or to read Peter's letter to Alan Johnson go to AvMA's website:

www.avma.org.uk

GOSPORT HOSPITAL DEATHS - WHAT CAN BE LEARNT?

The inquest into ten of an original 92 suspicious deaths at the Gosport War Memorial Hospital in the late 1990's began on 18th March. Amidst disappointment that a full public inquiry has so far been rejected by the Government, there is also hope that the inquest will at last uncover to what extent systemic problems at the hospital or individual malpractice by health professionals contributed to the deaths. It may also provide wider lessons for the NHS on patient safety in relation to the use of strong pain killing and sedative drugs ('opioids') and for the system of health professional regulation including the General Medical Council. AvMA is spearheading efforts to ensure that these opportunities are not lost and providing support to families who lost loved ones at

Gosport – whether or not they are included in the inquest itself.

The deaths at Gosport involve the use of diamorphine and other opioids on elderly and very ill people. The NHS is not blind to the dangers of opioid drugs. In 2008 the National Patient Safety Agency issued a rapid response report with actions required by January 2009, following receipt of 4,200 reports of patient safety incidents involving opioids. 880 of these are known to have caused harm, including five deaths. However, this could be the tip of an iceberg. The NHS reporting system is entirely voluntary and it is known many incidents are not reported. AvMA suspect that in cases involving elderly and very ill people it is much less likely

that errors and their consequences will be recognised.

AvMA has made arrangements for local specialist solicitors Blake Laphorn to represent families at the Inquest. Their help and that of barristers from Outer Temple Chambers is having to be provided largely on a pro bono basis due to the problems with obtaining Legal Aid for inquests. AvMA is also advising and supporting families not directly involved in the inquest.

To read more about this go to AvMA's news pages on the website:

www.avma.org.uk



National Patient Safety Agency

AvMA
44 High Street
Croydon
CR0 1YB

Phone: 020 8688 9555
Fax: 020 8667 9065
E-mail: anna@avma.org.uk



Registered Charity No. 299123 in England & Wales and in Scotland No. SC039683

www.avma.org.uk



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 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

Graham Tanner, Patient Safety Champion, noted an item in the BBC News on 13th February that stated *Intensive care errors 'frequent'*.

Errors in the administration of injected medication in intensive care units occur frequently, a study across 27 countries suggests. Austrian researchers collected data on more than 1,300 patients, 200 of them in the UK, over a 24-hour period. Of the 441 patients affected, seven suffered permanent harm and five died partly because of the error, the British Medical Journal reported. Medical staff often cited stress and tiredness as contributing factors. Data was collected by researchers from Rudolfstiftung Hospital from a total of 113 intensive care units, of which 17 were in the UK. Nearly half of the affected patients suffered more than one mistake during the period covered. The most frequent errors were related to the wrong time of administration and missing doses altogether. Cases of incorrect doses and wrong drugs being given were also reported. A total of 69% of the errors occurred during routine care. *Mistakes occurred with many types of drugs, including insulin for diabetics, sedatives and blood-clotting drugs.*

The doctors and nurses who took part in the study cited stress and tiredness as a contributing factor in a third of mistakes. Recent changes in the drug's name, poor communication between staff and violation of protocols were also mentioned. The odds of an error being made increased significantly for the most severely ill patients. Researchers said this reflected the complexity of their care.

In a statement, the Intensive Care Society said the aim must be to refine care to minimise drug errors. It said that critically ill patients often required complex care, with the use of many different drugs,

some unusual, which were often administered using specialist equipment. "The urgency of treatment can also mean that these drugs have to be located rapidly, prepared efficiently and administered quickly to prevent further deterioration. Unfortunately, this pressure does mean that the combined total incident rate is almost inevitably higher than in care areas where fewer medicines are required."

For more information and the full story see the BBC website.

NHS Complaints Procedures Changes

AvMA has had it confirmed by the Department of Health that the current bar on people having an NHS complaint investigated if they have started or intend to start litigation to recover compensation is to be lifted. The regulations which govern the new NHS complaints procedure, subject to parliamentary approval, will allow complaints and litigation to run concurrently for the first time. The move follows years of campaigning by AvMA. The new NHS complaints procedure comes into force on April 1st in England.

GMC Defeated in Attempt to Prevent Judicial Review

The General Medical Council (GMC) have suffered a defeat in their attempts to avoid a judicial review of their refusal even to investigate allegations of forgery and 'cover-up' by doctors involved in the case of Robbie Powell, aged ten, who died following neglectful treatment in South Wales in 1990. The High Court have granted Action against Medical Accidents (AvMA) – the charity for patient safety and justice – permission to progress to a substantive hearing in their action to overturn the GMC's decision.

For more information on this article visit the AVMA website:

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