

Patient Safety Champions speak at a series of Regional Events

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 meetings and initiatives under way around England and Wales to involve Patient Safety Champions. We'd like to hear from all of you in the wider Network about your activities and items of interest around improving patient safety.

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



Five regional venues were selected by the NHS Training Hub for Operative Technologies in Healthcare (THOTH) to hold their Workshop 'Managing the Consequences of Adverse Incidents'.

AvMA was invited to speak at the events in addition to arranging the Conference facilities. Patient Safety Champions gave presentations at each of the events too.

The day was designed by the organisers (THOTH) to enable NHS and patient groups and other organisations to work together to share ideas and experience, and create solutions to some of the difficulties faced by patients, staff and organisations when an adverse incident has occurred.

Including Graham Tanner (pictured above), Margaret Ogden, Bev Hurst, Chista Kermami and Gillian Bean were Champions who spoke about the experience of patients after an adverse incident has taken place, providing the patient perspective. These were very well received by participants and some people joined the Wider Network after hearing about the work of AvMA and this project from Peter Walsh and Anna Allford.

Other Patient Safety Champions and members of the Wider Network were also present at some of the events and contributed to the discussions designed to gather information that will be used by the organisers to produce their final report in January.

These events helped raise awareness of not only the role

of the Patient Safety Champion but the need to involve patients and families in all work around improving patient safety. NHS staff told us how useful they had found the opportunity to meet with their regional Champions and to have heard from them about their experiences.

Champions included the need to adopt the principles of Being Open (NPSA Policy, 2005) - see page 3 for more details. The benefits of Being Open when an adverse incident has been found to have happened were explained and further explored by participants. In AvMA's response to the Consultation on The Draft NHS Constitution, AvMA called for a Duty of Candour (or patients' "right to openness and honesty when things go wrong"). Read more about this online at;

www.avma.org.uk

Stop Press!

The Report of the first six months of the project will shortly be available on the AvMA website to view or download. Go to www.avma.org.uk/champions

Update on Champions and NHS Partners in England and Wales

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

- Patient Safety Champions in Yorkshire and the Humber, Iain Wordsworth and Narendra Mathur, have reported that the new Safety Manager of the SHA is now in post and they will be meeting her soon. They have put 'safety' on the annual programme of the Overview and Security Committee of Wakefield Metropolitan District Council. The Local Involvement Networks (LINKs) in Wakefield have also agreed to include safety on their annual programme. The LINKs will be asked to provide commentary on the Self declaration of the NHS Trust for the Health Care Commissioners' Care Standards. The first domain (Care Standard one to Care Standard four) deals with the safety issues. In Wakefield Narendra will be leading on items. Contacts are being established with LINKs in other parts of the region to also engage them in patient safety.

- Marlene Moura, Patient Safety Champion, has been working with the East of England SHA Patient Safety Strategy and is on the steering group for South West Essex LINKs. Champion, Peter Metherall is also pro-active in the area working towards improving patient safety.

- Stuart Stevenson Champion for Wales has been filmed for a video on behalf of the 1000 Lives Campaign and attended the launch of the bowel cancer screening kit as part of this Campaign. Meryl Davies, also a Champion in Wales and Stuart are to attend a training session from Julie Rix, Patient Safety Manager to update them on policy and changes in the structure of the Health Boards in Wales.

- NHS South East Coast recently had meetings with Champions, June Hitchcock and Darren Tamplin, to discuss ways forward in developing partnership working. June has also agreed to meet with the Health Care Associated Infections (HCAI) team as she has a special interest in this area.

- Jenni Dewhurst and Val Baker, Patient Safety Champions for London, have now met with the SHA and are discussing involvement in patient safety workstreams.

- Together with South Central SHA, Champions, Chista Kermani and Anne Carvalho have already taken part in a number of events and meetings and continue to have busy schedules with invitations to provide the patient perspective gathering momentum.

- NHS North East have welcomed Champions, Margaret Ogden and Mike Casselden to help develop their plans

and further involvement is scheduled.

- Beryl Nock, Champion, at a recent Board Meeting of NHS West Midlands got the agreement of the Board to include Being Open in the metrics. She also asked them to include a metric on learning from mistakes and how do you make sure these are implemented. Brian Osborne, Champion, continues to work locally to improve patient safety.

- NHS East Midlands is still yet to meet with Champions Gillian Bean and Susan George but their agreement in principle is extremely positive and a meeting to discuss partnership working is anticipated following the forthcoming November Workshop.

- Following a meeting with NHS South West, Champions, Graham Tanner and Simon Mathias have received information about the areas where their input can help the SHA and future involvement is being planned.

Additionally, Champions; Anne Carvalho, Simon Mathias and Stuart Stevenson together with Anna Allford, Project Manager, were invited to be judges at the Patient Safety Challenge. The event in Coventry saw teams from NHS Trusts, a private hospital and the MOD compete. They had to work on a simulated adverse incident. Many other events and meetings have been attended by Champions—thanks to all.

News reports and time to Coroner's Inquests

One day in mid July 2008 I hear on the local evening news on BBC 1 (Look North) about a coroner's inquest in the death of a grandmother following medical negligence.

This lady was prescribed Methotrexate orally to be taken once every day, by her GP instead of once every week, which of course was a gross overdose. Incidentally she was also taking the same drug (Methotrexate) once a week as prescribed by the hospital specialist (another gross error because of correspondence failure). I was absolutely furious about the unnecessary death, in spite of the fact that in July 2004 the NPSA issued an alert following

reports on the harm caused by oral Methotrexate. They issued a revised alert in June 2006 to try and improve the implementation of the previous alert across the NHS in England and Wales to ensure that all actions described in the original alert were completed and they also gave patient information leaflets and monitoring documents. These were produced in collaboration with the British Society of Rheumatology and British Association of Dermatologists. I spent a few more days trying to get further information about this tragedy.

At a stage in my investigations I found that the death occurred in the year 2004

before these two alerts were issued. A tragedy, but not as I originally thought due to lack of response to the alert. I would have saved a lot of my time if I knew the chronology of the events.

I have made further enquiries in Wakefield. GPs are well aware of the complications of oral Methotrexate but they appear unsure whose responsibility it is to give patients the information monitoring leaflet. I will make further enquiries on this particular aspect and feedback in the next newsletter.

*Narendra Mathur,
Patient Safety Champion*

10 Principles of Being Open

Extract from the Policy 'Being Open' © National Patient Safety Agency 2005

Being open is a process rather than a one-off event. With this in mind the following principles have been drawn up to underpin the policy. They can be adapted to meet the needs of individual healthcare organisations as a framework for developing local policies and procedures on openness. Some of the principles listed below are discussed in more detail in subsequent sections of this policy document.

How to communicate patient safety incidents: key principles, issues and procedures

- 1 Principle of acknowledgement
- 2 Principle of truthfulness, timeliness and clarity of communication
- 3 Principle of apology
- 4 Principle of recognising patient and carer expectations

- 5 Principle of professional support
- 6 Principle of risk management and systems improvement
- 7 Principle of multidisciplinary responsibility
- 8 Principle of clinical governance
- 9 Principle of confidentiality
- 10 Principle of continuity of care

See: www.npsa.nhs.uk

Wider Involvement Network

I have been collating information from the survey sent to everyone on the wider Network. Some of the issues and concerns you have raised resonate with others who have similar experiences. There is still time to send me your completed questionnaire and add to the wealth of knowledge that this project aims to utilise to help Patient

"My son suffered serious harm (paraplegia etc.) following an operation to remove a tumour on the spine."
Network member

Safety Champions provide the patient perspective in improving patient safety.

Post them back to me at the AvMA office (address on the back page) or email them to me, Anna Allford: anna@avma.org.uk

Patient Safety Champions and NHS Partners in the Northwest

22 May 2008 our quest for Patient Safety takes a new path. The journey begins: Excitement, anticipation, butterflies and trepidation, every emotion possible runs through your mind; 'who would I be partnered with' 'would it be friend or foe' 'would we get on, would we even like each other'. We (Patient Safety Champions, Bev Hurst and Ann Bisbrown-Lee) were both clear in our own minds from the start that the Patients for Patient Safety Champions for the Northwest could only really work if it was a bonded partnership.

Imagine our delight & surprise when we first met at the hotel shuttle bus-stop, the 'ooop' north accent was instantly easily recognisable and we both heaved a sign of relief that on first impressions we at least appeared to be friendly and amenable.

Ann Bisbrown-Lee is a retired Nurse/Nursing lecturer and is involved as a lay person on many committees within her local PCT. Bev Hurst has been raising awareness and campaigning for Patient Safety for many years and has supported a vast number of families through their painful and often traumatic issues. Both their

experiences mean between them they had a wealth of experience to draw upon and compliment each others strengths and weaknesses.

Our next hurdle was 'would our Patient Safety Action Team (PSAT) really want to work with us or was this just perhaps a tick box exercise?' Again **Result!** Sue Bothwell, our PSAT lead was a delight: cheery, bubbly and like us completely passionate about Patient Safety. Our first meeting with the PSAT took place at Northwest SHA headquarters and we have not looked back since. We were introduced to some of the PSA team; Angela Brown (Associate Director), Linda Ward (Assistant Director), Sonia Norris (HCAI Implementation Lead), and Nina Durrant (PSAT PA).

It is without doubt that the Northwest SHA has some of the most dedicated, hardworking members of staff that are completely committed to Patient Safety, each and every one of them have ensured that we are fully integrated with discussions and debates at every one of the events we have so far been invited to. These include:

- PCT Directors of Quality & Safety business meeting

- Patient Safety First Campaign workshop for the Northwest
- HCAI whole health economy Northwest conference

This has given us the chance to network with representatives from nearly every trust in the northwest including acute, primary, mental health, ambulance, commissioners and providers of service. This networking opportunity has produced invitations to work on specific projects such as a review of a Trust's Complaints procedure, many more have extended invitations to come in and present the patients perspective to staff training events. Coming up in the near future we have the Directors of Nursing meeting and a meeting with 5 Boroughs Partnership. We will continue to have regular development meetings with our PSAT at headquarters to ensure continuity. This whole opportunity has reaffirmed our passion and commitment for Patient Safety and has now given us the chance to be involved on a strategic level and hopefully help shape the way forward for the safety of all others.

Bev Hurst and Ann Bisbrown-Lee

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Productive ward visit



Recently Patient Safety Champions were invited to visit Barnsley Hospitals NHS Foundation Trust to see a 'Productive Ward'. It was a very positive visit for all concerned. Next Month Iain and Narendra will tell you more about what they found out.

Picture: (left to right) Angela Deacon (NHS Yorkshire and the Humber), Narendra Mathur and Iain Wordsworth (Patient Safety Champions), Sue Yoxall, Lead Nurse and Denise Tate, Matron (Barnsley Hospitals NHS Foundation Trust).

Round up of other news of interest

National Audit Office Report on NHS Complaints Confirms Patients' Fears

Action against Medical Accidents (AvMA) - the charity for patient safety and justice - has welcomed the publication of the National Audit Office report on NHS complaints, published on 10th October, saying it confirms their own experience but does nothing to diminish patients' fears about the robustness of the proposed new system.

AvMA chief executive, Peter Walsh, said:

"The report confirms our experience that the majority of patients do not complain and most who do, do not have their complaints done justice. Critically, the NHS misses opportunities to learn lessons from complaints to improve safety and quality. Whilst the NHS Complaints Procedure is about to be reformed, no one should be under any illusion that the situation will improve overnight. In fact, the situation could be made worse in the short term because of lack of resources and planning for the transition.

Our biggest concern is the adequacy of arrangements for independent review of complaints, given the planned abolition of

the Healthcare Commission. The Commission is already haemorrhaging complaints staff which will lead to problems and we are not convinced that there will be enough staff based with the Ombudsman to deal with independent review when the new system kicks in, in April 2009. We agree with all the intentions of the reforms but it is simply not good enough to wish local resolution of complaints to be better and assume it will happen. There should be guarantees that anyone needing an independent review of their complaint will get it. That will mean guaranteeing that the Healthcare Commission and Ombudsman are resourced to deal with at least the current numbers of requests for independent review, and that this capacity is not reduced until we see an actual reduction in demand for independent reviews. There seems to be a naive assumption that this demand will automatically reduce. The Department of Health should have learnt its lesson from the debacle when the Healthcare Commission was first created and the demand was far greater than they were resourced to cope with."

For more AVMA news visit the website:

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

Contact for FLAAME in UK

Cathy Horton who is based in the US suffered from a medication error several years ago while living in the UK (it was at a London hospital) and has since set up an organisation called FLAAME - Families Launching Action Against Medication Errors - www.flame.org She is working with Elaine Horton, who has suffered something similar here in the UK.

They are looking to try and connect up with individuals in the UK so that their messages and resources can be shared here. If you would like to make contact or know of any possible links, organisations or patients who might be interested in connecting with Elaine in the first instance please contact her email address: eshort@aol.com

Please send your items of interest to the Editor; Anna Allford at the AvMA address above or by email anna@avma.org.uk