

Patients for Patient Safety Project in England and Wales

Patient Safety Champions & NHS Partners Meeting in Birmingham

28th & 29th November 2008

Summary

Patient Safety Champions and NHS Partners met together on 28th November in Birmingham to discuss progress to date and share information about areas for involving Champions in the work of Strategic Health Authorities in England and NHS bodies in Wales. Each region provided a brief update.

In particular, during this 2 day meeting we were keen to explore and develop the role of the Wider Network – over 250 individuals, or lay people and healthcare professionals already directly engaged in working with NHS patients' safety improvement. Champions are figureheads championing the Wider Network and also Patient and Public Involvement in the NHS.

Our keynote Speaker was **Martin Bromiley**. Martin is “Dad” to a young family. Professionally he is an airline pilot with a background specialising in human factors. In 2005 his wife and “Mummy” to Victoria and Adam, died during a routine hospital procedure. As a result of his experiences he has been one of the founder members of the Clinical Human Factors Group, a non profit making charitable trust who aims to advise and promote best practice around human factors. See their website: www.chfg.org

Martin spoke about: Failures around non technical skills; Situational awareness; Leadership; Communication; Teamwork; Speaking up and listening. One of the ways of helping to improve safety in operating theatres is by use of checklists and Martin had found that by talking to Clinicians about how the airline industry investigates incidents this had helped the NHS think about system failures and how things sometimes go wrong.

After an update from Peter Walsh, AvMA's Chief Executive, on the Being Open policy and ways Champions can help address this with healthcare professionals, a discussion led to some shared thinking about future events around promoting this policy as the NHS National Patient Safety Agency (NPSA) prepares for a re-launch of the policy in the Spring of 2009.

Champions stayed on after the project's NHS Partners left on day one and on day two, preparation work began to develop questions to ask Trusts and PCTs about Being Open, for example, “*how do you monitor and evaluate your Being Open policy?*” and “*how do you inform patients and families when things go wrong in your care?*”

As awareness of Patient Safety Champions increases so does the demands on their time. As volunteers a fine balance is required between their current work/home life and the work they undertake providing the patient perspective. Individual Action Plans for completion by the Champions, similar to ones used by the World Alliance for Patient Safety, Patients for Patient Safety initiative, were provided to help Champions prioritise their tasks and also ensure their own interests and expertise are being taken into account. The project team suggested that these could be shared with their NHS Partners to explore the tasks Champions would like to be involved in and the time and commitment they can realistically make. Further training and development for Champions was also discussed.

We hope that people from the Wider Network can meet in the future with their Champions and healthcare professionals in regional meetings and through closer networking.

Day One Introduction

Peter outlined the programme for the 2 days and the intended outcomes, particularly the sharing of good practice and ideas for involving Champions and the Wider Network in current and future work to improve patient safety.

Anna Allford presented a project update and advised participants that the first meeting of the Strategic Advisory Group is scheduled to take place in February 2009, after which the majority of meeting would be virtual (either on the phone or by email). Additionally, Anna announced that she'd been invited to give a presentation at the Patient Safety Congress 2009. Two Champions will be invited to present on stage with Anna at this conference in April/May.

Several champions expressed disappointment at the fact that the NPSA were not represented at this event, and wanted reassurance that this did not reflect a lack of commitment to the project. Peter and Anna assured participants that representatives from the NPSA were unable to attend due to last minute work pressures and had sent their apologies.

The project team is developing a Code of Conduct and this was welcomed by participants as it can help provide a framework for their engagement with healthcare professionals and others.

Activities and developments across England and Wales

NHS North East

The work in this region is centred around clinical themes and reflects the Darzi work.

- Safer Care Clinical Team looking at mortality / morbidity
- Recently set up a Rural Health Care Commission and would like a Champion involved in this
- Safer Surgery – the SHA would like a Champion involved here also.
- Suicidal Workshop Analysis
- 10 key impact changes will be developed with all Trusts in their area.

Discussed possibility of recruiting further volunteers from the Wider Network to support the work of the Champions in this SHA.

NHS South East Coast

- Launched their own version of Darzi within the last 6 months
- World Class commissioning is being developed in association with how regional structures link within the SHA.
- Met with Champions - introducing Champions to colleagues
- Looking at expectations Champions / NHS colleagues within the project
- SHA colleagues expressed some anxieties and the implications of these are being followed through
- Champions attended a meeting with the Chief Executive and left the meeting with a list of issues – currently awaiting feedback on some of these issues.

- ? Opportunity for Champions to go on to the Quality Board
- Champion, June Hitchcock, attended a HCAI (Health Care Associated Infection) meeting and has been invited to the Clinical Governance Network meeting on Being Open.

NHS South Central

See Appendix 1 for more detail.

- Champions have been integrated into Forums – these forums are made up of Representatives within the Trust region
- Forums are a sub group of Federation Board – Champions are part of this
- Champions will be involved in *Patient's Voices* training videos
- Champions will also be part of SUI (Serious Untoward Incident) Review Group
- SHA wants Champions involvement in audit of SUI – Action Plan on how patient views are incorporated.
- **For the future** Worldclass Commissioning – Review of Patient Safety Cultural Audit planned for Jan 09
- Champions, Anne Carvalho and Chista Kermani, are featured on the Federation website www.patientsafetyfederation.nhs.uk

Anne agreed that Champions within the region were welcomed with open arms. Further involvement of the Wider Network was also felt to be needed in this region as calls on the Champions to get involved are increasing.

NHS West Midlands

See Appendix 2 for more detail.

- There had been problems maintaining communication with the Champions while the SHA put in new structures/positions but this has now been resolved and plans are underway to involve Beryl Nock, Champion, in future activities
- Beryl, has direct involvement with the Patient Safety Action Team (PSAT) and has recently been invited to sit on the Project 5 Board (Quality & Patient Safety)
- The SHA plan to involve Beryl in Being Open events
- Beryl will be asked to take part in the SUI Review
- Beryl will also be invited to join a small select group, Investing for health Design Group for Patient Safety.

Beryl felt that it had been a difficult few months having had so little contact with the SHA and without the background into some of the changes taking place internally at the SHA this had been de-motivating for her. Several issues around practicalities also needed to be resolved before Beryl could feel that an effective partnership could be realized, including; time and commitment need to be agreed, and Beryl also wanted to find out if she could claim travel expenses from the SHA. Anna Allford will attend their next meeting to discuss some of the issues.

Wales

Champion, Stuart Stevenson provided the update and said that after a slow start he'd sent emails to organisations to introduce himself and this had created an interest.

- Stuart attended the launch of the Bowel Screen programme for Wales on 28th October
- Stuart has been invited to help organise an Endoscopy Patient User Group

- Stuart has also featured in a DVD for the 1000 Lives Campaign related to (a) Health & Hygiene (b) Cancer
- Stuart also has further presentations and meetings planned.
- Julie Rix, NPSA, recently provided a training session for Champions which only Stuart was able to make in the end due to the family ill-health of Champion, Meryl Davies.

In Wales there has been little contact between the Champions and Patient Safety Manager, Julie, who only works in one region of Wales. Whilst major reorganisation of health services has been taking place within the country there remains difficulty in engaging the Champions at a strategic level within organisations and despite the endeavours of the project team to ask the Welsh Assembly Government to link the Champions into their Patient and Public Involvement network this has not yet been achieved. The project team is hopeful that as two members of the project's Strategic Advisory Group represent organisations in Wales this should open up further future opportunities for partnership working.

Julie has also been given a special remit by NPSA to take forward the Being Open policy and this may provide a firmer footing for Champions, Meryl and Stuart, to engage with Julie in this important aspect of current work that Champions nationally are adopting.

NHS East of England

See Appendix 3 for more detail.

- In this region Champions have challenged the normalisation of patient safety incidents.
- Champions will be invited to join the new programme board (in line with the Lord Darzi workstreams) and they will be included in the first meeting due to take place in December
- Patients Safety Solutions Focus Group will be held on 1/12/08 and Champions, Marlene Moura and Peter Metherall, have been invited to attend
- Nationally, this SHA lead on the Faculty of Experts (The Institute for Healthcare Improvement (IHI) in the US working together with NHS professionals) which will take Patients Safety forward.

Peter Metherall noted that he'd also attended a meeting regarding Blood transfusion Awareness and he had an active interest in Organ Donation and Critical Care. Again, it was stressed that there is a need for Champions to prioritise their time.

NHS Yorkshire & Humber

See Appendix 4 for more detail.

- Champions have been introduced to colleagues at Strategic Health Authority
- Talked about their areas of work and possibilities for involvement
- Visited a Productive Ward at the suggestion of the Director of Health
- Work on Image of Nursing linked to safety – report due
- GMC Affiliates Project Pilot Yorkshire & Humber meeting in January – Champions invited
- Infection Control Taskforce being set up – opportunity for Champions involvement
- Quality Taskforce
- Patients Action Team meets Quarterly – Champions / Anna invited to the next meeting.
- Event in January on Safeguarding patients

Iain Wordsworth, Champion, confirmed that the meeting with the Leeds team was very enthusiastic and the next meeting has been arranged to take place at Iain's house. Champion, Narendra Mathur, has also attended an Infection Control Meeting for which a Taskforce is being formed.

NHS South West

- After a slow start the SHA is still planning where to work with Champions and how it fits into Patients Safety
- Currently planning their Patient Safety Campaign, 34 organisations signed up to the campaign
- 4 organisations have completed the 2 year Patients Safety program
- 2 x Open Days will be attended by the Champions
- The SHA also has a programme of work around Venous Thrombo embolism (VTE) prevention
- Champions to be invited to Strategy Group
- Their National Conference is planned for September 2009 and includes one workstream around Being Open

Champion, Graham Tanner, was concerned that information for patients on HCAI should be routinely provided to help patients understand what they can do to help themselves. It was also noted that in Primary Care there are missed opportunities to improve patient safety.

NHS London

- Being Open is being looked at by the SHA
- Both Champions invited to SHA HQ and met with Patient Safety Action Team
- Champions have been asked to look at the SHA's existing Patient Safety Reference Group and how they can link-up
- The SHA has a draft Proposal for mapping the Darzi Review – looking at developing sharing network with trusts around the quality perspective.

Valerie Baker, Champion, who has involvement in Consultation Groups and Steering Groups at the South London & Maudsley Mental Health Trust reported that their SUI group is now closed off to service users.

NHS East Midlands

Gillian Bean, Champion, highlighted that although the SHA has yet to forge links with the Champions she has remained busy with issues of national interest, e.g. the removal of the Health Care Commission from the Complaints procedure. Gillian was also invited to give a talk at a recent NHS THOTH event. Gillian additionally has an interest in ensuring the physical health of mental health patients.

Correction: Gillian would like to qualify the above sentence as it may have been truncated during note-taking. She says "Whilst I would not deny that I have a general interest in promoting physical health in **all** patients, I have no special expertise for those with mental health problems. In fact in my work with SIN we concentrate on those patients who claim to have **physical** iatrogenic damage. We believe that those patients with mental health problems are well served with many support groups and organisations."

Champion, Susan George, said she'd been busy working on her mother's case which remained her priority and had therefore not been able to spend time as a volunteer to promote her role locally.

The project team expressed their concerns that the SHA has not been able to include the Champions in their work yet but confirmed that they would ask for a further meeting to discuss this as soon as possible, as Peter and Anna had recently been at a national PSAT meeting where Siobhan Heafield indicated she wished to meet with the project team.

NHS North West

See Appendix 5 for more detail.

Champions, Ann Bisbrown-Lee and Bev Hurst, congratulated the SHA on all of their work to incorporate them into their workstreams. They had already been involved in various pieces of work including being part of the orientation for patient safety managers at Trusts. Both Champions had attended several meetings and provided the patient perspective, in addition to Bev giving presentations. They said they felt it was working really well in the North West.

Keynote Speaker

Martin Bromiley gave a presentation on what had happened in his family following the tragic loss of his wife during a routine surgical procedure. Martin described his quest for understanding and sharing the lessons learned. He said he'd expected a full investigation into what led to his wife's death following attempted anaesthesia but when this didn't take place he encouraged the hospital to adopt some of the systems used by the aviation industry when investigating accidents as he is a pilot.

In understanding what can go wrong for patients it is necessary to consider:

- Failures around non technical skills;
- Situational awareness;
- Leadership;
- Communication;
- Teamwork; and
- How to speak up or listen to colleagues.

In aviation 75% of accidents are caused by human factors. Pilots are assessed 4 times per year and 50 per cent of their assessment is around non technical skills. Aids to help ensure aviation safety include:

- Briefing
- Worse case scenarios
- What to do in event of the above
- Use of checklist
- Reporting Systems.

He stressed that importantly Reporting Systems need to be simple and in aviation there is only one form to fill in. Additionally, disseminating information is vital for organisations to share learning from patient safety incidents.

Martin commented that Teamwork initiatives are being developed in the NHS with some individual trusts also starting to develop their own team working programme, however, there is a need to engender clinicians reporting poor performance. He felt that Champions could focus on driving this forward and suggested that Champions provide real experience of what has happened which is more powerful to clinicians than statistics. Martin felt that the Champions key factor should be around working out their “passion and perspective” and added that in his experience Clinicians respond better when presented with a positive approach to improving patient safety from patients and the public. He noted that there is already national interest from the Health Select Committee regarding Patient Safety Champions.

Martin was instrumental in forming the charity **Clinical Human Factors Group (CHFG)** last year. The CHFG is an independent body, set up as a non-profit making organisation. It has close links with many UK based healthcare bodies but sets its own agenda based on impartial, expert opinion. The members of the Standing Group are made up of specialists from both within and also outside the clinical professions who provide a diverse knowledge of human factors. Their goal is to increase awareness within clinical practice of human factors and how it can be used in the reduction of clinical error. Website: www.chfg.org

Champions had an opportunity to discuss some of the issues around coping with and managing the anger process that is associated with serious untoward incidents plus the systems already in place in the NHS, for example, the Complaints procedures. Martin commented that change in the NHS is slow but can be achieved with continued and concerted effort.

Promoting Being Open

Peter Walsh suggested ideas about how Champions can push forward ‘Being Open’. He asked Champions to speak with their SHA / PSAT partner to find out if they are doing anything at a regional level and to note this and feedback to project team. Where there are already plans then Champions could explore possible joint work with the SHA/PSAT. If it is not possible to build into their work programme then Champions could agree to keep them informed of their own work, e.g. with local NHS Trusts etc. A further way to keep the profile of this important policy raised is to explore the possibility of regional conference / seminar. Either specifically on Being Open or on Patient Safety generally but with Being Open a specific item. As the NPSA plan to re-launch this policy in the Spring of 2009, PCTs and local hospitals may wish to promote this to their staff and involve patients. The Project team/AvMA can help with logistics and can be contacted by the Champion or NHS.

Champions could research individual Trust / PCT policies and whether training has been provided e.g. how many and what kind of staff were involved? This is not performance management research but rather finding out what is being said on the various NHS websites about Being Open.

Offering to give talks to local NHS staff in trusts and PCTs would be an excellent way of contributing locally and support for Champions to do this is available from the project office. Champions could use their own personal experience or other case studies (AvMA can supply). Another area that Champions can explore is the possibility that they can help with

“Being Open” training. The project team will also be enquiring if Champions can be involved with Boards on Board training.

Other options for Champions are to:

- Promote the AvMA “Charter of Understanding”
- Ask Trusts/hospitals if any audit/research conducted on complaints / claims to identify if Being Open practice had been followed and sharing good examples through the project.
- Brief other people, for example, members of LINKs / CHCs what sort of questions to ask Trusts around their implementation of Being Open.

Champions may also like to research information on Trust / PCT websites about Being Open and their Clinical Negligence Scheme for Trusts (CNST) level. More information about the scheme can be found at the website of the NHS Litigation Authority www.nhs.uk

One participant commented that it is important to build on existing work and not to re-invent the wheel and cited the ‘Being Open Academy’ of the NPSA as not being utilized as much as it should. The project team and two of the Champions had recently attended a workshop where Professor Albert Wu, in his review of Being Open, identified an issue of cost as being a barrier to the current training.

Another participant noted that the Health Care Commission (HCC) does monitor the implementation of safer practice as part of their review and are helping NPSA with measure to monitor new safer practice notices. The successor to HCC is Care Quality Commission.

Jean Lowe said she’d done a review in London and asked the question ‘is the Being Open Policy reviewed?’ Angela agreed that she would explore existing work and how to access networks.

A Champion felt that the **NHS Litigation Authority Circular ‘Apologies and Explanations’** confused the issue of Being Open – devaluing apologies to regret being expressed at the outcome. This Champion had raised this point at a SHA meeting and a NHS Trust had replied that they wanted to give full apologies but due to the circular felt they had to send out standard responses. Peter explained that AvMA were trying hard to have the NHSLA circular replaced with more appropriate guidance. The NHSLA were very resistant, but he had raised the matter at the National Patient Safety Forum and hoped this would bring about some movement. The Welsh Health Risk Pool is also being approached about their equivalent circular and was much more positive about working with AvMA to improve it.

Benita Playfoot suggested that all Trusts need to be monitored to ensure they are using the policy but many would benefit from training. A further Champion felt that the NHSLA are not in touch with the reality of how Trusts handle apologies and that their conflicting advice causes more harm.

NHS/PSAT partners left at the end of Day one.

Day Two

Introduction

Peter outlined the planned presentations and development work for Champions. He re-capped on yesterday's discussions and suggested these would be continued today around Being Open culminating in a personal Action Plan being devised by Champions themselves.

Anna led sessions on 'Active Listening' and 'Asking Questions'. Champions were asked to think about how they can communicate effectively in meetings or when giving presentations by practicing some of the techniques.

Peter discussed further questions that could be added to the list started during the Being Open Masterclass that was attended by some of the Champions. Appendix 6 is the updated list of suggested questions but more can be added as this work is developed further. Peter felt that it may be helpful for Champions to attend Risk Managers meetings if possible and that with permission, anonymised information could be forwarded to AvMA where good practice has been achieved.

It was agreed that the following would be carried out by Champions and feedback given to the Project Manager:

- 1. Ask SHA / PSAT partner if they are doing anything at a regional level around Being Open. Record and feedback to project team.**
- 2. Explore possible joint work with SHA/PSAT. If not possible to build into their work programme agree to keep informed.**

Peter announced that NHS Connecting for Health www.connectingforhealth.nhs.uk is appointing a Patient Safety Lead and AvMA will update them on news about this when available.

The leaflet '*Listening & Responding to Committees: a brief guide to Local Involvement Networks.*' available from the Department of Health (www.orderline.dh.gov.uk Ref No. 290334) was distributed to Champions to provide background information about LINKs.

What hat are you wearing?

This discussion led by Peter highlighted that Champions may be seen as individuals, patients or representing the views of professionals at different times and by different groups. This can be difficult for Champions to reconcile and Champions need to decide what they are representing in each area or forum they attend. It was suggested that Champions conduct themselves according to the Seven Principles of Public Life (see Appendix 7). It is legitimate for Champions to be wearing different hats – working with other organisations but they need to be clear which hat is being worn as there could be conflict of interest.

Patients for Patient Safety Champions are championing:

- 1) Patient Safety
- 2) Patient and Public Involvement in patient safety, ensuring that patients/public can make a difference and reminding people that patients have a unique role.

Involving the Wider Network more is one way of ensuring views of the public and those with a specific interest in improving patient safety are heard. The project team will seek to put Champions in touch with local people who are part of the network where they agree to this level of involvement.

Personal Action Plans

Action Plans adapted from those produced for the Patients for Patient Safety initiative of the World Alliance for Patient Safety formed the basis for further discussion about how Champions can seek to be involved in local and national work to improve patient safety. They are to be used as a personal reflection to set out the objectives for each of the champions. Timescales and identifying what success will look like help Champions to keep the plans realistic and it was suggested that these are shared with their SHA/PSAT partners when completed.

Future Support & Project Development

Champions were keen to have more information about the WHO/World Alliance for Patient Safety (WAPS) structure and a slide included in the template being designed for them by the Project Manager that outlines the relationship between NPSA/AvMA and WAPS. Anna will request further clarification from Rachel Heath at WAPS.

Information about NPSA workstreams was felt to be important so that Champions could be included. The Being Open Policy is the main theme for Champions at the moment but there will also be an opportunity to get involved in work on the Patient & Public Reporting system in the future. One Champion suggested that they could help with developing the national learning system too.

The report of Prof. Albert Wu's findings on the Being Open Review was requested. Anna will check with NPSA to see if this has been published yet.

Other possible stakeholders such as the Patients Association were discussed but Peter said that they are only London based and therefore regionally it would be highly difficult to link into them plus there are many other important stakeholders already in existence locally (including LINKs/CHCs).

A leaflet is being developed for Champions and the project to use highlighting the aims of the project and the role of Champions and the Wider Network. A draft will be distributed for comment when prepared.

Some Champions felt it would be useful to send letters to local newspapers to raise the profile locally. The project team can help draft these with individual Champions if requested.

Training and Development needs:

One Champion suggested that the skill sets of Champions could be drawn on by other Champions. Anna agreed to ask Champions to let her know who would be prepared to give a training session in their specialised subject. This could then be offered to small groups.

Information about Root Cause Analysis was requested as the next group training session and the project team agreed to arrange a facilitator/trainer together with a date for this in the Spring if possible.

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NHS South Central

Over 140 NHS staff from Trusts across Berkshire, Buckinghamshire, Oxfordshire, Hampshire and the Isle of Wight attended the first Annual Patient Safety Federation (PSF) conference on Wednesday 5 November at the The Ark conference centre in Basingstoke.

Our Patient Safety Champions were joined by delegates from across the South Central region including Chief Executives, Chairs, Non-Executive Directors (NEDs), a range of medical and nursing staff and Allied Health Care professionals.

Presenters for the day included:

Katherine Fenton Director of Clinical Standards and Chief Nurse at South Central Strategic Health Authority (SCSHA) opened the day by welcoming everyone and posing the question: 'What are the aims and aspirations we would like to deliver in a NHS South Central Patient Safety Strategy?'

Setting the context of the day Jim Easton, Chief Executive SCSHA raised five challenges:

1. We must **all share our intelligence and metrics** with regards to incidents thus producing 'a joined up working process' which will deliver an open and transparent process which will enable greater awareness of Patient safety issues.
2. If we are serious in supporting the work being undertaken by the PSF we must each **resource** the PSF appropriately, as at present there is insufficient funding to enable the work stream projects to be delivered.
3. SCSHA will become a **clinical organisation** with an emphasis on Clinical leadership.
4. **Organisation Boards** must have patient safety as the number one item that under pins all their work. Non executive Directors must be engaged and all serious untoward incidents should be questioned and supported. 'There is no room for acceptance of the normalisation of harm this is unacceptable'.
5. **Measurements.** 'We need to talk maturely with one another about Patient safety/ Performance Management issues.' World Class commissioning must be used as the catalyst to deliver patient safety.
6. **Leadership and the Board role in Patient Safety.** Peter Cavanagh, Patient Safety consultant from Somerset PCT explored the role of the Board and the NEDs in challenging poor practice to stimulate the questioning of Directors.
7. **A Patient story.** Patient Safety Champion Anne Carvalho raised many questions with regards to her story and midwifery services, which was a stark and evident reminder of the long-term effects Serious Untoward Incidents have on patients.
8. **Update from the Patient Safety First.** Murray Anderson Wallace informed us that we now have 11 Trusts signed up to the campaign. He also gave an overview of the contents of the campaign and next steps.

A plenary session was held where all speakers answered questions from delegates on a variety of issues including the five challenges discussed in Jim Easton's presentation (which will be discussed a little later on).

Over lunch a short video was presented from the leads from the work stream detailing the actual projects in place and future plans. Work streams covered were:

- No needless Falls
- No needless Hunger or Thirst
- No needless Ignorance.

Posters were on show covering the following:

- No needless Falls
- No needless ignorance - human factors
- Metrics development
- No needless medication errors
- No needless skin breakdown
- Patient Safety and Risk Managers Forum which is a sub group of the Federation Board.

Following lunch **Phillipa Slinger, Chief Executive of Berkshire Mental Health Foundation Trust** presented on Patient safety within a Mental Health setting, focusing on suicide, both in the out-patient and also the in-patient setting.

Greame Zaki Medical Director for Portsmouth Hospitals Trust gave a detailed account of the challenges facing all staff at acute hospitals within his Trust.

The **National Patient Safety Association** had three representatives presenting at the conference:

Julie Jones discussed the new Patient Safety Direct programme with the emphasis on inclusion from all Trusts to deliver a National Serious Untoward Incident Policy and a devolved electronic reporting system. This prompted a very lively virtual debate post conference and a workshop has been set up for the Patient Safety and Risk Managers Forum on 18 November, where stakeholders can actively take part in developing the national policy and systems. Our Patient Safety Champions will play a very important role in providing the patients perspective at this workshop.

Joan Russell gave a very interesting presentation on the 'Safe Surgery Saves Lives' campaign which included the WHO surgical checklist this was most opportunistic as NHS South Central are actively rolling out the WHO surgical checklist.

Tanya Huehns presented 'Never Events' post consultation and the way forward, which was well received and generated many questions from the delegates appertaining to the list of eight identifiable events and a process whereby these would be implemented. This reiterated what Jim Easton had discussed earlier in the day and supported the non acceptable normalisation of serious untoward events.

The day was drawn to a close by **Gail Byrne Head of Patient Safety** at SCSHA where she emphasised Jim Easton's five challenges and the Patient Safety Strategy. The conference closed with Gail requesting that all delegates should give some thought as to how they would deliver at least one aspect of the Patient Safety strategy in their own trust.

A DVD and the presentation from the Patient Safety Federation conference are available for viewing from the Federation website at **www.patientsafetyfederation.nhs.uk**

NHS West Midlands

1.Recent developments/achievements:

Due to work commitments one of our patient safety champions has decided to continue with his local champion work at Worcester PCT and will be less formerly active with the PSAT.

The remaining patient safety champion has been actively engaged with regards to meeting the PSAT and in particular the Director of Public Health. The PS Champion has been appointed to sit on SHA Investing for Health project 5 -Patient Safest and Highest Quality Services in the Country

2.Recent Learning and Initiatives:

Importance in maintaining good communications with champions on a regular basis

Planning the diary

3.Key Challenges:

Issues around the role of patient safety champions both from the PSAT and Champion view point

Getting started has proven to be difficult due to commitments and demands

4.Plans for the next quarter:

To continue with Patient Safety Champion on Project 5

To coordinate diary

To possibly be involve in Being Open events – this may however be part of Project 5

To work with PSAT Patient Safety Manager when teaching / facilitating organisations in programmes of training such as RCA , Pre Reg Student Nurse.

A Hulme PSM

PSAT

NHS East of England

Patient Safety East of England

Patient Safety has been given a high profile and has been set as a high priority within the East of England. The strategic health authority has agreed to the establishment of a programme board, in line with the 8 clinical programme boards originating from the Lord Darzi work streams. Patient safety cuts across all the other programme boards and therefore will have a presence in all the work streams. The 10th programme board will be working on patient experience and satisfaction therefore a close link will be formed between this group and the patient safety group.

The key work areas of the implementation plan for the programme board will be:

- To establish a programme board. The chair of the board has been selected and commenced November. The membership of the board is being confirmed with the first meeting to be held in December. Both of the patient safety champions will be formally invited to join the programme board.
- The initial priorities of the programme board:
 - To develop a supportive infrastructure to support all the programmes of work
 - To improve the management of the acute deteriorating patient
 - To ensure that Venous Thrombo Embolism screening is implemented in every acute trust
 - To develop a programme to improve management of anticoagulation across primary and secondary care
 - To continue to reduce health care acquired infections
 - To improve medicine management
 - To improve patient safety in mental health

National Patient Safety Campaign

We held a joint meeting in October where the national campaign team came to talk to the Trusts across the East of England who had signed up to the national campaign. One of our patient champions attended the meeting and gave their point of view when the floor was opened up for discussion.

Working with Industry on Solutions

Within the East of England we are holding focus groups to discuss with our partners in industry and education technical solutions to our every day problems. One of the focus groups to be held in December is focusing on patient safety and both of the patient champions will be present.

This is an exciting time for patient safety and the establishment of the programme board will ensure that this is taken forward and given the high priority it should be given across all health care settings.

Mavis Spencer

NHS Yorkshire and the Humber

OVERVIEW OF CLINICAL QUALITY AND PATIENT SAFETY DEVELOPMENTS

Background

'High Quality Care For All' published in June 2008 states that 'high quality care should be as safe and effective as possible, with patients treated with compassion, dignity and respect.' The renewed emphasis on quality and safety at national level reflects developments in Yorkshire and the Humber, where there has been significant progress over the last year.

Following the DH report 'Safety First', a NHS Yorkshire and the Humber Patient Safety Strategy 2007-2010 was developed in consultation with key stakeholders. The strategy was ratified by the SHA Board in October 2007 and was subsequently communicated to a wide audience across the region, including Chairmen and Chief Executives of Trusts and PCTs. To support implementation of the strategy, an action plan has been produced. The SHA's Patient Safety Action Team (PSAT) is responsible for delivery of the action plan and progress is monitored on a quarterly basis.

Key Achievements

- Establishment of a SHA PSAT in line with the recommendation in 'Safety First'. The team includes experienced risk and governance managers, clinicians with specialist expertise and safety champions for patients to highlight the patient's perspective in relation to safety issues.
- SHA Board development sessions held on corporate manslaughter in May 2008 and on patient safety in October 2008, including analysis of trends in incident data.
- Intensive performance management of healthcare associated infections, with regular reports to the SHA's senior management team and Board. A Regional Healthcare Associated Infection Taskforce is to be launched on 26 November 2008.
- The Quality in Contracts Project is working to develop clinical indicators of both safety and quality.
- A pilot GMC Affiliates project has been initiated in West Yorkshire on behalf of the Department of Health. This is exploring the linkage between organisational governance and professional regulatory requirements.
- Established links with the Bradford Institute for Health Research, which is currently developing undergraduate medical training to include patient safety as a core and assessed subject throughout the programme.
- Three patient safety networks (mental health, acute and PCTs) are now established, with senior representation from all PCTs and Trusts (including Foundation Trusts) across Yorkshire and the Humber. A baseline assessment of patient safety activity in all Trusts and PCTs has been completed by network members and the SHA has fed back SUI and other incident data to network members for benchmarking purposes. The three networks have shared best practice in safety, quality and governance and learning from incidents locally and nationally eg safeguarding, out of hours primary care and the outbreak of *C Difficile* at Maidstone and Tunbridge Wells NHS Trust. All the networks have made progress against their annual workplans. They have recently reviewed how they will enhance their effectiveness in the future, including capitalising

on opportunities such as participation in the national 'Patient Safety First' campaign, the 'Leading Improvements in Patient Safety' (LIIPS) Programme and 'Safer Patient Initiative' (SPI). Following discussion and recognising the risks of not attending to other safety issues, the networks have agreed priority workstreams up until the end of March 2010 as follows:-

- Mental health network – risk assessment and management, patient engagement and compliance with treatment, and communication.
 - Acute sector network – deteriorating patient, falls, infection prevention and control.
 - PCT network – safeguarding, increasing incident reporting in primary care, infection prevention and control.
- Developed a patient safety and governance section within the SHA's new website (available to NHS staff) to include resources eg root cause analysis and shared learning.
 - Staged a number of major learning events, with audiences of around 100 people. These included an event in December 2007 to improve the effectiveness and sharing of learning from independent investigations in mental health, an event in March 2008 entitled 'Safety Connections – Delivering World Class Care', with a keynote address by Professor Aidan Halligan and an event in November 2008 entitled 'Implementation of NICE Guidance – A Celebration'.
 - Revised clinical audit and effectiveness criteria for commissioners and providers and delivered targeted support to particular organisations. There has been an increase in networking and the shared use of proven tools and techniques across the NHS in Yorkshire and the Humber.

Karen Warner
Patient Safety Manager

NHS Northwest

We have introduced Bev and Ann to the PCT Directors of Quality and Directors of Nursing in the North West, and they have contributed to a number of key patient safety workshops, including the Patient Safety First Campaign workshop in September and the HCAI whole health economy conference in October.

We are working with them to develop strategic partnerships and bring a patient/public perspective to our work to reduce health care acquired infections and harm to children, and, through the Patient Safety First Campaign, make the safety of patients everyone's highest priority. They are also working with NHS Trusts to explore different ways of using their expertise and develop links with existing patient and public networks in the region to promote the 'patients for patient safety' concept.

For example they have accompanied colleagues from Western Cheshire PCT on Friday 14 October on a walkabout at a hospital, attended the clinical governance managers network meeting to explore the potential for a coalition for patient safety across the north west, and will be helping us explore if and what clusters are needed to support the Patient Safety First Campaign at a meeting in December. We have also had some requests to meet with Directors of Nursing after the fliers were sent out to PPI leads across the north west, and are arranging meetings to follow up on these.

A key theme running through all our work is to promote and embed *Being Open* (NPSA, 2005). We will be working with the NPSA to re-launch this important national policy during 2009, and supporting local organisations implement it.

Sue Bothwell

Being Open policy (NPSA,2005)

Patient Safety Champions may wish to ask some of the following questions when discussing Being Open with health care professionals/NHS Trust Leads. (Please note these should not be sent in the form of a questionnaire or survey but are for use in meetings and one-one discussions).

- How many patient safety incidents do you report?
- How do you learn from Complaints?
- Do you have a Being Open policy?
- Who has been trained in Being Open?
- How do you monitor Being Open?
- How do you evaluate it? Has there been any audits/research to find out if Being Open practice has been followed.
- Do you have your Board involved in Patient safety – and if Yes, then how?
- Has the Trust audited your complaints and claims/litigation – and how many went through to compensation?
- What happens about staff raising complaints?
- How did you evidence your implementation of Being Open in your submission to NHSLA for your CNST level?

The Seven Principles of Public Life (as recommended by the Nolan Committee)

Holders of public office should take decisions solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family, or their friends.

Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties.

In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

Holders of public office should promote and support these principles by leadership and example.

These principles apply to all aspects of public life.