Patient Safety Forum Members

Professor Bernard Crump
Chief Executive Officer, NHS Institute for Innovation and Improvement

Lord Darzi
Parliamentary Under Secretary of State, Department of Health

Andrew Dillon CBE
Chief Executive, National Institute for Health and Clinical Excellence

Sir Liam Donaldson
Chief Medical Officer – England, Department of Health

Martin Hetcher
Chief Executive, National Patient Safety Agency

Dr Tony Jewell
Chief Medical Officer – Wales, Welsh Assembly Government

Professor Sir Ian Kennedy
Chairman, Healthcare Commission

Dr Michael McBride
Chief Medical Officer – Northern Ireland, Department of Health, Social Services & Public Safety

Dr Martin McMahon
Director of strategy, Planning & Health Outcomes, Lincolnshire Primary Care Trust

Dame Gill Morgan
Unite executive, NHS Confederation

Joe Neanor
Patient safety & investigations, Department of Health

David Nicholson CBE
Chief Executive, National Health Service

Hemant Patel
Headsant, Royal Pharmaceutical Society of Great Britain

Lord Patel
Chairman, National Patient Safety Agency

Stephen Ramsden
Chief executive, Luton and Dunstable Hospital NHS Foundation Trust

Dr Rashmi Shukla
Director of Public Health, NHS West Midlands Department of Health (Government Office – West Midlands)

Stephen Thornton
Chief Executive, The Health Foundation

Stephen Walker CBE
Chief Executive, NHS Litigation Authority

Peter Walsh
Chief Executive, Action against Medical Accidents

Professor Kent Woods
Chief Executive, Medicines and Healthcare products Regulatory Agency

To order further copies of Safety First: One Year On, call the NHS response line on 08701 555 455, quoting NPSA reference 0688.
Foreword

In December 2006, Safety First was published and made 14 recommendations for improving patient safety in the NHS in England. It was not the first document to outline issues around patient safety and to propose ways in which safer patient care can be better implemented across all health sectors. However, it was the first direct challenge to the NHS to take patient safety seriously and to put it at the top of everyone’s agenda.

The 14 recommendations emphasise areas where we must improve and change the way we work. While there is continued awareness of issues relating to patient safety, it isn’t always a priority. Senior leaders in the NHS have agreed on the priority through their participation in the Patient Safety Forum that was established in February 2007.

In Safety First, I highlighted four major themes:

1. The need to redouble our efforts to implement systems and interventions that actively and continuously reduce risk to patients. Healthcare will always carry risks; human beings are fallible. However, harm to patients should not be viewed as an acceptable part of modern healthcare.

2. When errors occur and risks are identified, we need much better ways to ensure that they are addressed so that their effect on patients and healthcare workers can be quickly mitigated. A quick response is vital. This must not only encompass the specific healthcare organisation where the event occurred, but the NHS as a whole. At the moment we are simply too slow to act to ensure that other patients are not harmed by the same sources of risk.

3. We need to encourage and support competent, conscientious and safety-conscious health workers in frontline services. We need to create an environment that motivates and indeed inspires them to insist that all care must be as safe as possible.

4. We need to restate the importance of strong leadership within NHS organisations. Safety does not have the priority it needs at the top of all our healthcare organisations. This must change if we are really going to put ‘Safety First’.

At the end of the first year, I believe we have made sound progress. However, we cannot afford to rest here. Many initiatives have now started. Some are in direct response to last year’s report; some are initiatives that the NHS has realised must happen as an outcome of an incident, an issue or an independently evaluated situation that has occurred because of unsafe patient care. We must learn from past errors and benefit from solutions that have been developed both in England and other countries. The safety of patients is an international issue and we can take the lead in contributing to the learning that will develop as a result of our work.

This report comments on the work being done in response to the original 14 recommendations of Safety First. I congratulate the individuals and teams throughout the NHS, and the many other supporting health-oriented organisations, who have accepted the challenge and are committed to putting patient safety first.

Sir Liam Donaldson,  
Chief Medical Officer  
for England
Introduction

Sir Liam Donaldson, Chief Medical Officer for England
David Nicholson, Chief Executive, National Health Service

This report has been produced to highlight and showcase the results of the first year’s achievements by the NHS, supported by many other health-related and associated organisations, in meeting the challenge of Safety First, that was published at the end of 2006.¹

The report was the culmination of a review to ‘reconsider the organisational arrangements currently in place to ensure that patient safety is at the heart of the healthcare agenda.’ It also focused on the National Patient Safety Agency as the organisation with patient safety as its main agenda.

¹ Safety First: a report for patients, clinicians and healthcare managers. Department of Health. 2006
The review, which took four months to complete, found that while some progress had been made, patient safety wasn’t always given the priority it should. Concerns were raised that the National Reporting and Learning System (NRLS), a world first for enabling local incidents to be recorded and analysed nationally, wasn’t functioning as capably as anticipated and had yet to deliver the level of learning on patterns, trends and underlying causes of harm to patients necessary to influence change.

The National Patient Safety Agency (NPSA), as the organisation responsible for the NRLS, was achieving a high success rate with the collection of data, however the ability to quickly analyse incidents and initiate appropriate responses that would contribute to improving patient safety was not progressing rapidly enough.

Being identified as a world leader through highlighting the importance of patient safety in the report An Organisation with a Memory, published in 2000, the UK must retain this profile by tackling safer patient care more visibly and giving emphasis to the role of the patient as well as the services provided by clinicians and the support provided by management. This more structured approach is part of the 14 recommendations outlined in Safety First and forms the basis of the response in this report.

The test, as Safety First identified, of how far and to what extent patient safety is more of a priority in the NHS, will be reflected in the cultural shift that occurs, the improved patient experience and a decline in the number of incidents due to improved practice.

With this in mind, implementing the 14 recommendations cannot be achieved in isolation from each other. Each links with another, for example, the success of a network of patient safety champions will depend on NHS staff agreeing with, and being involved with, the network’s establishment.

The success of a campaign to embed a culture of patient safety in the NHS will depend on managers as well as clinical teams supporting the initiative and agreeing with the principles. The creation of Patient Safety Action Teams (PSATs) working within the orbit of the Strategic Health Authorities (SHAs) will depend on the way in which the SHAs themselves liaise and link with their individual regional health networks.

Improving the NRLS to provide a quicker response back to trusts will depend in large measure on the speed with which trusts report local incidents and the rapidity of the response being distributed to everyone who can benefit or learn from the information that is gathered. At the same time, speed cannot compensate for quality. The circle will be completed when everyone locally understands the imperative of reporting into a national system, that the more serious incidents are prioritised and that the response is swift and useful.

The people who have most at stake are the patients. This is the imperative for improving safer healthcare and for adopting the principles outlined in the Patient Safety Campaign (see Recommendation 3 on page 10). By signing up to the aims and objectives of the campaign, the NHS will be agreeing to, and supporting the imperative of a paradigm shift in organisational culture and, as stated in Safety First, reaffirm the place of patient safety at the heart of the healthcare agenda.

On behalf of the Patient Safety Forum, which has oversight of much of the 14 recommendations, we applaud the work done to date and endorse the need to move forward with urgency.
Recommendation 01

As the next round of national goals, priorities and targets are being established from the period from 2008, it is important that the NHS takes steps to ensure that patient safety is further deeply embedded as a core principle that underpins these priorities.

Introduction
Patient safety sits at the heart of the Department of Health’s new Health & Social Care Outcomes and Accountability Framework. This sets out objectives and performance indicators for Primary Care Trusts (PCTs) as commissioners of services for the period 2008-2011. Commissioners have a key role in establishing and monitoring quality requirements in the services they commission.

Achievements and Progress
The first goal within the Departmental Strategic Objective, Better Care for All, is: ‘We will provide you with the safest possible healthcare’; an overall performance indicator based upon achievement of risk management standards. This aims to provide a concrete measure of safety improvement across services commissioned by the NHS.

A further goal within this strategic objective is ‘We will treat patients in a clean and safe physical environment’ with a performance indicator of incidence rates of MRSA and Clostridium difficile.

An interim national contract for acute services, introduced with effect from 2007/08, provided commissioners with the opportunity to negotiate local requirements for quality and safety. This included nationally mandated requirements for the reduction of Clostridium difficile.

The revised NHS Standard Contract for Acute Services, to be published with the Operating Framework for 2008/09, will identify the requirement to meet nationally mandated quality indicators and will provide the opportunity for SHA and local Commissioner quality indicators to be included.

Patient safety is also central to the Government’s reform programme for professional regulation, announced in February 2007 in the White Paper Trust, Assurance and Safety and the Government’s response to the Shipman Inquiry’s 5th report. This programme sets out a new system of revalidation to support all health professionals in improving their practice and to provide periodic assurance that they are up to date and continuing to practise to a good standard.
The way forward

Under proposals for the regulation of health and adult social care, healthcare providers in both the NHS and the independent sector may be registered against a set of requirements focusing on safety and quality. Providers who fail to meet these requirements would need to improve their quality of care or face action.

Legislation to implement these proposals was announced in the Queen’s Speech and introduced into Parliament in November 2007.

A consultation on the details of the registration system, including proposals for registration requirements, will follow shortly.
Case Study 01: Academy of Medical Royal Colleges

As a member of the Patient Safety Forum, we are able to represent work achieved by all the Medical Royal Colleges and Faculties across the UK. The highlights of the year are outlined below.

Safer Care for Acutely Ill People
A new report from the Royal College of Physicians, *Acute Medical Care: the right person, in the right setting, first time*, is produced by a task force that comprised over 40 representatives directly involved in clinical care for acutely ill people in acute and community care settings. It sets out a new vision for acute medical services in the UK to improve patient care and save lives.

National Clinical Audit: Care and Prevention of Falls
This audit was carried out by the Royal College of Physicians. It shows that most PCTs and trusts are nowhere near meeting national standards and guidelines from the National Institute for Health and Clinical Excellence (NICE), Scottish Intercollegiate Guidelines Network (SIGN) and the National Service Framework for Older People on the care and prevention of falls. It shows that inadequate service is being provided by most local health services and that there are unacceptable variations of care.

Safer Radiotherapy
The Royal College of Radiologists has established a multi-professional working party whose report, *Towards Safer Radiotherapy*, will be published in Spring 2008.

Interventional Radiotherapy: The Royal College of Radiologists is pressing hard for major improvements in interventional radiology necessary for safer care in the management of circumstances, for example, post-partum haemorrhage, upper and lower gastrointestinal haemorrhage, modern trauma care, and their integral part in the work of units undertaking transplant programmes.

Performance Standards in Pathology: The Royal College of Pathologists introduced an accreditation system for laboratory performance which is now universally accepted and followed. In conjunction with other organisations, it has developed an out of hours reporting policy for abnormal results, standardisation of reference ranges and cancer data sets.

Investigative Training in Human Pharmacology
The Faculty of Pharmaceutical Medicine is in the process of establishing a training programme and qualifications in human pharmacology for those involved in conducting exploratory studies of investigational medicinal products in man.

Patient Safety Research
In September 2007, the Faculty of Public Health, the World Health Organization (WHO) World Alliance for Patient Safety, and University College London hosted the first pan-European conference on patient safety research. Some 400 academics, policy makers and representatives from funding institutions met with the aim of agreeing priorities for patient safety research in developed and developing countries.

Safer Anaesthesia
Several initiatives have been developed as collaborative projects involving the Royal College of Anaesthetists, British Society of Gastroenterologists, the College of Emergency Medicine, the Royal College of Paediatrics and Child Health, Faculty of Dental Surgery, patients and the NPSA.

“We have only commented on the work being achieved in England this year. It is particularly notable that so many activities are conducted in broad partnerships involving patients and the public as well as the NHS and the regulatory and inspection bodies. Working together they are able to give force to the iterative cycle necessary to achieve continuing improvement in safety.”

Professor Dame Carol Black, Chair, Academy of Medical Royal Colleges
Case Study 02: Luton and Dunstable Hospital NHS Foundation Trust

Patient safety has been top of the trust’s agenda for the last five years. When The Health Foundation selected Luton and Dunstable Hospital as one of the four pilot sites to become an exemplar site in patient safety for the Safer Patients Initiative (SPI), we were inspired to accept this challenge and started SPI work in January 2005. The trust has now entered the two year phase of sharing the learning across the NHS.

The traditional approaches to patient safety: clinical governance, risk management, incident reporting, quality assurance and regulation are essential, but not enough. We have taken a far more proactive approach to patient safety, seeking transformational goals and have implemented 29 improvement measures. This has involved the setting up of five separate work streams to lead the work and we are proud of our results.

This year, the trust has taken a transformational approach to patient safety by the introduction of No Avoidable Infection and Pressure Ulcer strategies, which have led to a significant reduction in infections and pressure ulcers. Case note review has reduced by 70 per cent over the two year period.

Hospital Standardised Mortality Ratio (HSMR) is one of the measures that we use to measure the overall impact of these safety measures. Prior to undertaking this work, the figure stood at 111, which is 11 per cent worse than the national average; it is currently around 90 which is 10 per cent better. This is an encouraging sign that the raft of measures put in place to improve safety are beginning to have a significant impact.

“The Luton and Dunstable Hospital has made real progress in saving lives and reducing harm to patients as the original England pilot site for The Health Foundation Safer Patients Initiative. We hold ‘spread events’ every three months to share our learning with the rest of the NHS. These events are provided free of charge to delegates thanks to the generosity of The Health Foundation.”

Stephen Ramsden, Chief Executive,
Luton and Dunstable Hospital NHS Foundation Trust

Case Study 03: National Patient Safety Agency – safer care for acutely ill patients

Ensuring acutely ill patients are treated effectively is an imperative for hospital staff. However, serious incidents can and do happen.

Research and data analysis undertaken by the NPSA has highlighted two key areas relating to safer care of acutely ill patients: clinical or physiological deterioration not recognised or acted upon, and resuscitation after cardiopulmonary arrest.

Safer care for the acutely ill patient

The NPSA undertook a comprehensive analysis of serious incidents reported to the NRLS, along with litigation data and research in this area. A report, ***Safer care for the acutely ill patient: learning from serious incidents***, was published in July 2007 and highlighted patterns and themes, and areas where action can be taken to improve patient safety.

By identifying the two key themes of deterioration and resuscitation, and giving frontline staff guidelines and recommended actions for improvement, the report aims to contribute to a reduction in the harm caused, and even the number of deaths.

Recognising and responding to signs of deterioration

In November 2007, the NPSA published ***Recognising and responding appropriately to early signs of deterioration in hospitalised patients***.

Work leading up to the publication included identifying the underlying causal and contributory factors in deterioration incidents.

The report should be used by healthcare staff in tandem with the NICE guideline on acute illness in hospitalised adults, launched in July 2007.

“Patients should be able to feel confident that should their condition deteriorate in hospital, they are in the best place for prompt and effective treatment. This report sets out why deterioration incidents happen and helps NHS staff working in acute hospitals to improve patient safety in this area in a very practical way.”

Dr Kevin Cleary, Medical Director, NPSA
Recommendation 02

The Department of Health should establish a National Patient Safety Forum, jointly chaired by the Chief Executive of the NHS and the Chief Medical Officer (England), to harness the skills and expertise of a number of organisations, agencies and stakeholders which are making a significant contribution to patient safety.

Introduction
As patient safety becomes more important, an increasing number of organisations are becoming more involved in safety related work. This is a welcome development. However, it also brings with it the need to ensure that there are effective ways of promoting coordination and information exchange on work underway and to strategically consider national safety issues of interest across many organisations.

With this in mind, in February 2007, Chairs, Chief Executives and other representatives from 20 leading health organisations in the UK came together to establish a national Patient Safety Forum. Their aim has been to strengthen joint working to further embed patient safety as a priority in the NHS.

The Forum, under the joint chairmanship of Chief Medical Officer for England, Sir Liam Donaldson, and NHS Chief Executive, David Nicholson, has agreed that its focus should be strategic rather than operational. The Forum has met quarterly during 2007. It has provided an important opportunity for information exchange and discussion of the implementation of the Safety First recommendations and patient safety more broadly, for example, the NHS Review being led by Lord Darzi, Our NHS, Our Future. Organisations that make up the Patient Safety Forum are listed on the inside front cover.

The way forward
The Forum will continue to meet regularly during 2008. Further information about its work is available through the secretariat: joe.neanor@dh.gsi.gov.uk
Case Study 04: Monitor – The Year in Review

Monitor holds trust boards responsible for the delivery of clinical quality. It has the power to formally intervene if quality of care is being compromised, whether through financial instability, a failure to meet national targets and standards, or significant failings reported to it by the Healthcare Commission or other key stakeholders. As a member of the Forum, Monitor talks about progress made towards patient safety.

As the independent regulator of NHS Foundation Trusts, Monitor's objective is to improve all aspects of patient care, including the safety of services, through rigorous risk-based regulation.

In April 2007, we published an updated version of our Compliance Framework which is designed to ensure that NHS foundation trusts act within their terms of authorisation to provide the best and safest care possible for patients. The Framework identifies potential safety issues through the use of healthcare targets and standards so we can monitor situations closely and act quickly if necessary. Ideally, we can anticipate and address potential issues rather than reacting to them.

The success of the Foundation Trust sector and of Monitor's regulatory regime was illustrated by the findings of this year's annual health check from the Healthcare Commission. All 19 trusts rated excellent for quality of services and use of resources are NHS Foundation Trusts.

Cambridge University Hospitals NHS Foundation Trust is a good example of how Monitor works with foundation trusts to improve patient safety.

In 2006/07, the trust breached its annual MRSA target. It then reported concerns about its trajectory to meet the year-end target for the first quarter of 2007/08. Monitor required the trust to provide an MRSA action plan and monthly monitoring reports on progress. Both the trust and Monitor liaised with the Department of Health's Intensive Support Team to ensure the action plan was robust and achievable.

Implementation of this action plan led to improved performance in the second quarter, with the trust now in a much better position to achieve its annual MRSA target. As well as participating in several national initiatives, the trust has developed its own internal campaign – Take 5! Standards for a Clean and Safe Hospital. This is a programme of regular audit relating to infection control and hospital cleanliness which won the Elsevier Award from the Foundation of Nursing Studies and was praised for its robust attitude to audit using continuous feedback to maintain and improve standards.
Recommendation

The National Patient Safety Forum should oversee the design and implementation of a national patient safety campaign-focused initiative. The objective of this initiative should be to engage, inform and motivate clinical staff and healthcare providers to address the challenge of providing safer healthcare.

Introduction
In July 2007, the Patient Safety Forum supported a strategy to develop a campaign which will win the hearts and minds of those providing services across the NHS and stimulate them to take actions to make care safer. The key priority is to improve the implementation of known safer practices.

The framework of the campaign is designed to:

- Reduce safety incidents and avoidable harm through the implementation of evidence-based solutions and measure improvements.
- Garner momentum and enthusiasm amongst healthcare professionals and managers to develop a stronger patient safety culture within organisations.
- Build capacity and capability to continuously improve patient safety.

The NPSA is leading on the design of the campaign in collaboration with the NHS Institute for Innovation and Improvement (NHSIII) and with the contribution of the independent charitable organisation, The Health Foundation.

Achievements and Progress
The two year campaign covers three distinct areas. The first is to work with frontline staff to identify what the problem is that needs addressing. The second will identify the interventions that can help address the problem and the supportive resources that will assist with implementation. The third will be to measure achievements.
The way forward

The campaign will be formally launched in early 2008, ideally as a flagship initiative of the 60th anniversary of the NHS. Partnership links will be created with other national campaigns and in addition aim to have some shared ways of working with similar campaigns in Scotland, Northern Ireland and Wales.
Recommendations 04 & 05

The role of the National Patient Safety Agency should be refocused on its core objective of collecting and analysing patient safety data to inform rapid patient safety learning, priority setting and coordinated activity across the NHS. A number of current functions, for example the development of technical solutions to improve patient safety, presently delivered by the organisation should in future be commissioned from other expert organisations with the requisite expertise.

Introduction
Detecting and analysing safety hazards and risks through effective reporting systems is the cornerstone of patient safety. Since 2004, the NRLS has been successfully connected to NHS organisations in England and Wales, with over 1.8 million reports of incidents reported by staff in the NHS received by the end of September 2007. During the year, these data have been used to develop a range of recommendations to service providers about strategies to reduce risks to patients and improve patient safety. However, much more can and should be done.

“We want to ensure that the NRLS is a valuable knowledge resource for local organisations. To achieve this, improvements must be made. In the past, it has been too difficult to get quickly to the most important issues; there has been insufficient feedback to staff; data quality is variable and poor; and reporting is still difficult for key staff such as doctors. We must do better.”

Martin Fletcher, Chief Executive, NPSA

Achievements and Progress
The NPSA has engaged with over 800 stakeholders in the NHS to find out what information collected through the NRLS could best help frontline staff to improve patient safety. Clear messages emerged, including the need to build on the strengths of the existing national system; timely and targeted feedback following reporting; addressing the needs of different specialities; a single route of reporting where possible; and greater assurance that the most serious harm is being reduced.

Scope for improving the core NRLS data set has been identified with expert advice and guidance from John Hopkins University School of Medicine in Baltimore, USA. The preliminary report states: “the National Reporting and Learning System of the UK National Patient Safety Agency is perhaps the world’s most advanced system and is in a unique position to provide global leadership on the development, implementation and use of patient safety reporting system data.” Concerns include the degree of under-reporting of errors, the level of variation in reporting medical errors across trusts, the variable quality of reports and the fact that there is significant missing data within them, and the extent to which “free text” data poses analytical challenges.
Publications 2007

Rapid Response Reports:

• 26/11/07 Paraffin skin products: fire hazard with paraffin based skin products on dressings and clothing
• 10/9/07 Haemorrhage: emergency support in surgical units: dealing with haemorrhage
• 03/09/07 Injectable amphotericin: risk of confusion between non-lipid and lipid formulations of injectable amphotericin
• 18/06/07 Cytaberine: risk of confusion between cytaberine and liposomal cytaberine (Depocyte)

Patient Safety Observatory Reports

• Safety in doses: medication safety incidents in the NHS (analysis of 60,000 medication incident reports)
• Slips, trips and falls in hospital (analysis of 200,000 reports of falls)
• Safer care for the acutely ill patient: learning from serious incidents (analysis of 1,804 serious incidents)
We have also worked with trusts to test out new approaches including:

- Setting up an early pilot with 15 trusts to explore new methods of rapid reporting of most serious incidents. Over 190 serious incidents were reported from the participating trusts. The outcome is a new Rapid Response Report system which is now in place (see page 13).

- Engaging with clinicians, for instance identifying ‘risk registers’ with orthopaedic and renal teams as well as working with anaesthetists to set up a pilot specialty-specific reporting system.

- Analysing serious untoward incident (SUI) data as early scoping of more streamlined reporting.

- Continuing to improve feedback reports to trusts on their reporting.

- Improving the timelines and presentation of quarterly NRLS data summaries. Six quarterly data summarys have now been published on the NPSA website.

During 2007, we have also developed new ways of working with clinicians. The greater involvement of clinicians is core to our work.

**Anaesthesia: Improvement through Partnership**

This project is a collaboration between the NPSA and the Royal College of Anaesthetists. The group has identified four key areas of work: the development of a speciality based reporting system, double checking for injectable medicines, the management of throat packs, and the introduction of anaesthetic work stations.

**A Collaborative Approach to Cancer Care**

This project is being led by the Royal College of Radiologists. Three working parties have been set up: a patient safety radiotherapy group, a patient safety chemotherapy group, and a missed and/or late diagnosis group.

The chemotherapy group has completed an expert analysis of incidents involving chemotherapy reported to the NRLS. The group has identified three top priority areas to take forward. As a result of this work, the NPSA will issue a Rapid Response Report to promote the use of oral anti-cancer medicines.

A working party set up by the Royal College of Radiologists has written ‘Towards safer radiotherapy’. The guidance will be published this winter.

**Safer Practice in Neonatal Care**

- Approximately 35 per cent of babies admitted to neonatal units require transfer between hospitals.

- Medication errors account for more than 18 per cent of incidents involving the newborn that are reported to the NPSA.

- Neonates rank among patient groups at highest risk of healthcare associated infection.

Care bundles will be developed in neonatal transport, medication errors and blood-born infection.

**Improving Patient Safety in Intra-partum Care**

On 26 April 2007, the first meeting was held between the NPSA and the Royal College of Obstetricians and Gynaecologists. Two subgroups have been established to develop initiatives that will improve safety for placenta praevia following a previous caesarean section and foetal surveillance. A third subgroup has been established to consider the type of evidence to support this development.

“Positive clinical engagement is the key to improving patient safety. These initiatives will go a long way towards greater understanding of critical health issues and how they can be resolved with a more strategic and partnership approach.”

Lord Patel, Chairman, NPSA
Patient Safety Direct

Patient Safety Direct is an opportunity to make it easier for frontline staff to report patient safety incidents via a single portal. Currently the main line of reporting incidents is though the NPSA's reporting and learning system. Patient Safety Direct will strengthen this reporting line by adding a new and more accessible portal for NHS staff and ultimately patients to use.

The NPSA is scoping the work with all the various organisations that need to be involved. Plans will be developed in phase two of Lord Darzi's NHS Next Stage Review and, following piloting, we expect to move to implementation by the end of 2008.

The way forward

The immediate priorities are:

• Take the lead in setting up Patient Safety Direct, a new initiative resulting from the NHS Review by Lord Darzi which was announced in September 2007.

• Standardise and simplify NRLS core dataset quality standards for trusts.

• Improve feedback reports to trusts.

• Strengthen speciality-based learning and reporting.

• Progress the commissioned initiatives being developed by Royal Colleges.
Case Study 05: GMC – assuring safety for patients and equality for doctors

The General Medical Council (GMC) implemented a new registration framework for doctors on 19 October 2007. This is the latest stage in the GMC’s continuing programme of reform with the delivery of safe, high quality care for patients at its heart. Key features of the framework include the abolition of limited registration and the introduction of GMC approved practice settings. President of the GMC, Sir Graeme Catto explains.

We now require international and UK medical graduates who are either new, or returning to full registration, to work initially within a practice setting approved by the GMC. The purpose is to provide public protection by ensuring that doctors who are unfamiliar with the responsibilities of practice under full registration must work in environments where there is suitable support and supervision.

In order to ensure a cohesive and coherent approach to assuring patient safety, the criteria we use to assess an organisation’s approved practice setting status are mapped closely on those used by the quality assurance bodies in the UK.

To demonstrate an organisation’s suitability they must be regulated or quality assured by an independent body, and must have systems in place for:

• the effective management of doctors;
• identifying and acting upon concerns about doctors’ fitness to practise;
• acting on and learning from complaints;
• supporting the provision of relevant training or continuing professional development;
• challenging discrimination, promoting equality and respect for human rights;
• providing regulatory assurance.

The new framework also means that all new applicants for full registration must now satisfy the GMC, at the point of registration, that their fitness to practise is not impaired. This, coupled with a new power to erase doctors who are shown to have failed to disclose a relevant fitness to practise matter at the time of registration, puts us in a better position to protect the public.
Case Study 06: Lincolnshire Primary Care Trust – Putting Patient Safety First

Safety First was published at a critical time for Lincolnshire PCT, given that the trust was established only two months earlier. A priority for the PCT was establishing fit for purpose systems and structures which have patient safety embedded in both the commissioning and provision elements. Here the PCT outlines its achievements since then.

One of the key priorities for the trust has been to consult with the public in its ‘shaping health for Lincolnshire’, to develop a set of criteria and principles with patient safety as the key theme which in future will inform the PCT’s commissioning intentions and decisions. Initiatives undertaken this year within the PCT to strengthen the patient safety culture locally include:

- Established a system of engaging GPs and other clinicians in clinical governance and patient safety, linked to the Practice Based Commissioning clusters.
- Introduced a set of clinical and patient experience metrics for all providers as part of their contracts focused around patient safety indicators.
- ‘Walk the patch’ visits with providers have been introduced with a specific focus on patient safety, the patient experience and clinical leadership.
- A ‘learning from experience’ group has been established which has patient and public involvement and draws on the outcomes of complaints, incidents, claims, coroner’s reports, recommendations from prison ombudsman death in custody reviews, and other forms of intelligence, to capture and disseminate organisational learning. A quarterly report goes to the PCT Board.

- A robust practitioner performance model has been established to ensure that patient safety is the upmost priority in addressing clinical concerns.
- A Board committee has been established to champion and oversee the PCT’s approach to responding to the views of patients on their experience of using the NHS.
- Greater clinical engagement has been a priority, including GPs, optometrists, community pharmacists and dentists to help their understanding of patient safety and its importance, and the Healthcare Commission’s Core Standards.
- Robust safety alert processes have been established within the PCT and the development of our staff to be able to identify, report and investigate patient safety incidents have been addressed by Expert Incident Investigator training, risk management training for all new managers and patient safety training as part of induction for all staff.
- A clinical governance review of the PCT out-of-hours service has been completed with a focus on patient safety using the outcome of complaints, incidents and other forms of feedback to drive through a range of improvements.
- The PCT Prescribing and Clinical Effectiveness Forum has been established to inform the PCT commissioning decisions which has stakeholder engagement and is focused on patient safety as an imperative.
- The contracting process has been strengthened ensuring a clinical governance and patient safety wrap around the contract with quality standards contained in all contracts.
The Patient Safety Management function currently delivered by the NPSA should be hosted by Strategic Health Authorities and recast as ‘Patient Safety Action Teams’ to support the delivery of the national patient safety agenda by local NHS organisations. The team should consist of experts with skills in data analysis, incident investigation and solution development.

Introduction
Representatives of the ten SHAs met in early 2007 with the NPSA and other NHS organisations, including foundation trusts, to endorse the recommendation and to identify the composition and key functions of the Patient Safety Action Teams (PSATs). They are:

- Support the local, regional and national approach to patient safety.
- Build local capacity and capability in incident reporting, analysis, response and investigations, and implementation of safer practices.
- Lead performance improvement in patient safety at a local and regional level.
- Provide local to national links as part of a coordinated network of PSATs.

The teams will consist of core personnel and draw on a range of skills and knowledge. Each will be underpinned with quality, intelligence, information and analysis. Part of their role will be to explore how analysis and feedback from the NRLS can be more accessible and better inform local priority setting.

Achievements and Progress
PSATs have been established in the ten SHAs since 1 October 2007. Our vision is that the teams will make a practical difference to build a stronger culture of safety on the frontline. Key components of this approach include better local action planning for patient safety, clear priorities underpinned by data from the NRLS and other sources of knowledge, and work with trusts, frontline staff and commissioners.
About half of the action teams’ work will be driven by local needs and the other half will be driven by national initiatives. The NPSA has a role in working with the PSATs to agree national priorities for local delivery in the areas of incident reporting, analysis, response and investigation, and implementation of safer practices. The NPSA will also support a national network of PSATs.

Because progress on patient safety requires concerted action from a wide range of players, the teams will establish and become part of active collaborative networks in their local health communities. Some innovative practices have already been developed.

NHS South Central has established a patient safety federation that brings together a collaborative grouping of chief executives and trust directors, the NPSA and the NHSII. In the NHS East of England, a patient safety steering group has been set up, chaired by a trust chief executive, with involvement of senior trust representatives from across the region.

![The way forward](Image)

**The way forward**

The NPSA will work with the SHAs to determine the long term arrangements and priorities with effect from 1 April 2008. This will include:

- Working with the Foundation Trust Network to capture feedback on the experience of foundation trusts with these new arrangements.
- Convene national network meetings to describe the national vision for the PSATs and the national priorities for action for 2008/09.
- Formalise a process by which national priorities are agreed for PSATs on an annual basis.
In April 2007, a project team was set up by the NPSA to progress work on learning from patient safety investigations. Discussions were held with risk groups, a patient and public involvement group, and the Department of Health.

**Achievements and Progress**
Several resources have been developed by the Patient Safety Manager’s team leading this work as an outcome of the discussions. The packages are currently out for consultation across the NHS. They are due for publication in January 2008.

Prime responsibility for incident investigations should reside with local NHS organisations. Resources are:

- Best practice patient safety investigation report guidance and template
- Patient safety witness statement guidance and template
- Patient safety investigation credibility and thoroughness evaluation tool
- Patient safety investigations status log

Every NHS organisation should have access to a specialist investigator based within the Patient Safety Action Team. All reports should be considered locally within 24 hours of being reported. The NPSA should be notified of events that involve serious harm and death within 36 hours of the initial report.3

---

3 The response to Recommendation 9 is focused on the first part. Timing related to reporting and notification is covered in the response to Recommendation 5.
Experts should play an active role in ensuring learning is shared across the NHS as quickly as possible. Resources being developed are:

- A proposal for NHS-wide sharing of information from completed patient safety incidents, claims and complaints investigations which includes a response strategy involving feedback and learning via reports, cause and effect story telling and search facilities
- Minimum credibility and thoroughness criteria for collection of investigation findings

Specialist investigators working with PSATs should have access to specialist support and resources for investigations that have national significance. Resources are:

- Criteria to define issues of national significance
- Standardised tools and templates for use by specialist investigators in the NHS
- A database including links to investigation resources, experts and advice at the Department of Health, the NPSA and the NHSIII

The way forward

The proposal for NHS-wide sharing of information from completed patient safety investigation reports requires final approval and development into a data capture, response and learning facility.

Additional work on training modules and other more innovative methods of improving understanding of error and patient safety among clinical staff and managers is under way.
Case Study 07: National Patient Safety Agency – cleanyourhands

In October this year, we launched Year Three of the acute cleanyourhands campaign in England and Wales. It is one of the most successful NPSA projects, which aims to create an embedded culture of good hand hygiene that is recognised as a critical part of infection control and prevention within the health sector. All NHS acute trusts have signed up to the campaign. NPSA Chief Executive, Martin Fletcher, explains:

Introduction

Since the cleanyourhands campaign was launched in 2004, the NPSA has been supporting NHS organisations to improve the hand hygiene of their staff through a practical and sustainable toolkit, the cornerstone of which is the availability of alcohol handrub at the point of patient care. This enables healthcare workers to clean their hands quickly and effectively when they are with the patient.

The other key elements of the approach are materials to remind staff to clean their hands, involving patients in improvement, and supporting local campaign co-ordinators with tools and resources to engage staff at all levels of their organisation.

The campaign is part of the WHO's Global Challenge, which has more than 50 nation signatories, and is recognised as a leader in its field with several countries adopting our designs and materials.

Achievements and Progress

The campaign has already been effective in changing the hand hygiene of healthcare workers in acute NHS hospitals in England and Wales. Staff and patients throughout the NHS are now familiar with the campaign and we are looking to build on this for Year Three of the campaign in hospitals with a much harder-hitting and bolder approach.

The success of the campaign has also been recognised externally and in 2005 it won the Chartered Institute for Public Relations award for integrated campaigns and the Design Business Association internal communications award, as well as their overall Grand Prix award.

Evaluation Programme

The campaign in hospitals is subject to ongoing evaluation by a research team involving the Health Protection Agency, the Centre for Communicable Disease Surveillance, the London School of Hygiene and Tropical Medicine, University College London and the Hand Hygiene Liaison Group.

This multidisciplinary study will provide an independent assessment of the campaign and whether it is sustainable over time. Results so far are encouraging. Six months after implementation, 75 per cent of infection control teams thought the campaign was a top priority for their organisation. Since the campaign's inception, there has been an increased use of both handrub and soap. Hand hygiene audit and feedback takes places every six months in at least 75 per cent of wards. We aim to lift this rate higher with the new harder-hitting campaign materials and the increased public concern in infection rates.

The Way Forward

This year the NPSA began a pilot programme with the aim of introducing the cleanyourhands campaign to mental health, primary care and care trusts in England, as well as ambulance trusts, care homes and hospices in both England and Wales.

At the same time, work is underway to begin a two-year pilot of patient empowerment, the result of a proposal from the Chief Medical Officer for England, Professor Sir Liam Donaldson, in his annual report this year.
Case Study 08: MHRA – Safeguarding public health

The Medicines and Healthcare products Regulatory Agency (MHRA) ensures that medicines and medical devices work and are acceptably safe. It makes a significant contribution to patient safety in a range of areas from the publication of Medical Device Alerts through to issuing safety guidance on medicines. Chief Executive, Professor Kent Woods outlines some of the Agency’s projects achieved in the past year:

This year, the MHRA has published over 80 Medical Device Alerts to the NHS and social care via the Safety Alert Broadcast System (SABS), based on more than 8,000 adverse incident reports. These have covered different types of medical devices including assistive technology, intensive care, implants and diagnostic equipment. We have developed promotional activity to encourage patients to report adverse events experienced when using devices.

As the UK Competent Authority for the Blood Safety and Quality regulations, we have refined SABRE, our online haemovigilance reporting system, and used its serious adverse events and reactions reports to help inform risk based inspections of blood establishments and blood banks.

In collaboration with the Department of Health, the MHRA has formally approached the European Commission with a view to ensuring test kits for vCJD are included in the highest risk category of the IVD Directive.

We have worked very closely with the NPSA, providing advice for the development of the Rapid Reporting pilot and are a member of the Advisory Group on safety reporting and learning. The MHRA and the NPSA continue to collaborate on the redesign of the NRLS so that risks to patients are identified and appropriate action taken and communicated.

Our Enforcement and Intelligence Unit has been very successful in locating and prosecuting importers and handlers of counterfeit medicines, including unravelling the biggest conspiracy of the supply of counterfeit medicines thus far in the UK.

The MHRA has continued to have regular meetings with the NPSA on patient information about medicines and on other issues of mutual interest. We have contributed to guidance developed by the NPSA on labelling of injectible medicines and on guidance concerning the design of dispensaries and the way in which dispensing labels should be drawn up and applied.

We have launched a new publication, Drug Safety Update, to ensure that we communicate important information about medicines to those that need it in a timely way; and we have continued to produce our publication “One Liners” about device issues, including targeted editions for particular groups of healthcare staff.

“Safer patient care is a concern for all of us, and the MHRA continues to have a proactive role in developing solutions to issues that relate to our portfolio. We have worked very closely with the NPSA and other organisations this year and look forward to further positive progress being made that will contribute to keeping patient safety at the top of the healthcare agenda.”

Professor Kent Woods, Chief Executive, MHRA
Recommendation 08

Accountability for patient safety rests with the Chair and Board of each NHS organisation. Each Board should therefore be expected to outline how it intends to discharge this responsibility. Importantly, each Board should also make clear how it intends to ensure that patients and carers play an integral part in all initiatives to introduce a patient safety culture change within the NHS.

Introduction
The reviews of professional regulation Good doctors, safer patients and The regulation of the non-medical healthcare professions highlighted the need for clarity about the respective responsibilities of local employers, local commissioners and regulators, and for close cooperation across the interface between them.

The Government’s proposals in response to these various reviews were set out in Safeguarding Patients, the formal response to the Shipman Report and other inquiries, and in the White Paper Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century. The Professional Regulation and Patient Safety Programme takes the Government’s response into the next phase and is a key deliverable in the Department of Health’s Business Plan 2007/08.

Achievements and Progress
One of the work streams following on from the reviews is to improve systems for local investigation and local decision making to ensure patient safety and quality assurance through revitalisation of relevant clinical governance processes. The guidance is expected to be published by the Department of Health and promoted in Autumn 2008.

A separate strand of work by the Department of Health aims to provide guidance to Boards on focusing all governance systems (clinical, financial, corporate) on quality outcomes in order to maximise clinical and patient outcomes for the resources invested. This guidance is expected to be published and promoted in Spring 2008.
The way forward

The way in which Boards utilise the guidance provided for them will determine how they discharge their responsibility in terms of their contribution to improving quality outcomes and patient safety across the NHS in line with the expectations of Recommendation 8 in Safety First.
Recommendation

The approach of the Healthcare Commission in monitoring progress in patient safety should be further developed into a high-profile programme which comprehensively monitors and assesses progress against national and local standards and indicators of performance. PCTs should be accountable for ensuring that all providers used by their patients have effective patient safety reporting systems and are implementing technical solutions satisfactorily.

Introduction
The Healthcare Commission’s Annual Health Check of NHS organisations, which results in the ratings of Quality of Service published each October, looks at an organisation’s corporate approach to safety and some key targets that link to safety. Nearly half the core standards in the Department of Health’s Standards for Better Health are related to safety issues. A third of the National Minimum Standards used to assess the independent healthcare organisations are also related to safety.

Achievements and Progress
In the assessment relating to performance in 2006/07 we looked at progress against the developmental standards relating to safety through a range of indicators. In the 2007/08 and 2008/09 assessments, the Healthcare Commission will be developing further the use of indicators both to include within the trusts’ Annual Ratings and to provide information which benchmarks trusts’ performance against that of similar organisations. The Healthcare Commission is developing indicators on outcomes in safety, in discussion with NHS organisations and clinical groups, to inform its future decisions.

The Commission supplements the broad assessment of performance described with more indepth reviews of topics of particular importance. Our current and future programme includes assessment of Compliance with the Hygiene Code and the Ionising Radiation (Medical Exposure) Regulations.

The programme of Inspections of compliance with the Hygiene Code will be extended beyond NHS acute trusts to include the community and the independent sector. We are developing a significant programme of work to improve our ability to assess other important aspects of safety, such as responses to safety alerts and the safe use of medicines and medical devices. A consultation document on the Healthcare Commission’s forward programme including the aspects relevant to safety will be published towards the end of the year.
The way forward

The Healthcare Commission can, and does, undertake investigations where it has evidence of potentially serious service failures. It has extended its work recently to identify and follow up on information received about increased mortality in particular services. To build on this, the Commission aims to work with the Department of Health, the NPSA and others who have action underway on Recommendations 5 and 7 of Safety First to ensure that the information on serious untoward incidents which is currently reported to a range of bodies is brought together systematically and triggers appropriate follow up action.
Recommendation 10

A pilot should be established to examine the option of NICE developing technical patient safety solutions.

Introduction
The Patient Safety Pilot Project was formally initiated in April 2007. Current projects are:

- Medicines reconciliation on admission to hospital (guidance to be issued to the NHS in England on 12 December 2007)
- Prevention of ventilator-associated pneumonia (guidance to be issued to the NHS in England in 2008)

Developing the Pilot
The NPSA identified medicines reconciliation as a major patient safety issue from their analysis of adverse incident reports submitted to the NRLS. Prevention of ventilator-associated pneumonia was chosen because of high-profile national and international work that had already been carried out. Choosing two diverse topics made the project resilient and gave the opportunity to involve a wide number and range of stakeholders in the pilot.

A stakeholder event held in May 2007 was attended by approximately 60 people from the Department of Health, NHS trusts, patient groups, academic bodies, NHSIII, industry representatives, professional and medico-legal organisations, and health regulators. In addition, a Patient Safety Advisory Committee was recruited mainly from current and past members of NICE Advisory Bodies, including the Interventional Procedures Advisory Committee and the Technology Appraisal Committee.

Achievements and Progress
A systematic review of the evidence was carried out by the Review Body of the interventions, and an economic model was constructed for each. These were presented to the Committee at its first meeting in September. The Committee also sought expert opinion on the topics from specialist advisers nominated by their professional organisations, and from patient groups. The Committee considered this evidence and advice in the context of national and international initiatives related to the topics from bodies such as WHO and the IHI, and made its initial recommendations on both topics. These were sent out for public consultation in September.

Final recommendations were considered in October. NICE and the NPSA collaborated on stakeholder development and implementation. NHS trusts and related bodies were consulted on what support would be most effective in promoting implementation of the guidance.
“This has been a very exciting opportunity for NICE. Our extensive experience stood us in good stead for developing guidance on new safety solutions for the NHS. The core principles we apply to all guidance development – the use of independent expert committees, genuine public consultation and an open decision-making process – have all been applied to this project. We are confident that the resulting guidance will make an important contribution to realising the Chief Medical Officer’s aim that patient safety is at the very core of NHS policy and NHS care.”

Andrew Dillon, Chief Executive, NICE
The NHS Institute for Innovation and Improvement should be asked to work with the medical Royal Colleges and other educational providers to ensure that advances are made in education and training to support patient safety.

Introduction
The NHSIII has created a new Priority Programme, ‘Safer Care’, which is a three year programme of work leading on the implementation of Recommendation 11 and contributing to Recommendation 3 of Safety First. The ultimate aim of the Priority Programme is to: ‘build an NHS where every member of staff has the passion, confidence and skills to eliminate harm to patients.’

Achievements and Progress
Progress to date includes:

- The first four-day Leading Improvement in Patient Safety (LIPS) course has been held in England with a nurse and senior consultant from 23 NHS hospital trusts attending. Each team has produced safety work plans and testing plans for their organisations which were shared with their chief executive(s) on the final day of the event.

- Support for 13 senior doctors and leaders to attend the eight-day Patient Safety Officer’s course at the IHI in Boston, USA. The NHSIII has two Fellows who have also now attended the programme.

- Four senior NHS Executive Teams have attended the Executive Quality Academy at the IHI.

- Nine university partnerships are now piloting safety and improvement modules. Independent evaluation is showing very positive results.

- The Safety First agenda has been successfully linked to many of the Institute’s existing programmes which are generating significant clinical interest (for example, Clinical Systems Improvement Training and Productive Ward).

- There have been very positive responses to a proposal to establish a Safety and Improvement faculty. A small steering group has been set up, chaired by Professor Dame Carol Black, Academy of Medical Royal Colleges, with its first formal meeting on 3 December 2007.
The way forward

We continue to work closely with our partners, the NPSA and The Health Foundation on the development of the Patient Safety Campaign due to launch in 2008.

- The first Quality and Safety Academy for Senior Leadership teams will take place in January 2008, targeted at the senior leadership teams from the 23 organisations who attended the LIPS course.
- Three NHS places are secured for three senior clinicians to attend the nine-month IHI’s Improvement Advisors course beginning in February 2008.
- The NHSIII is assisting the Department of Health’s Cleaner Hospitals team to commission a development programme for 500 infection control specialists and microbiologists to begin in January 2008.
- Two further LIPS courses will be run during the coming year with 25 organisations attending each.
- The NHSIII is also establishing a programme of safety events in partnership with Royal Colleges, with the first two joint events booked at the Royal College of Surgeons.

“We aim to ensure that patient safety has its rightful place in the education and development of clinicians and managers. This is a vital component of the creation of the safety culture we all want to see.”

Professor Bernard Crump, Chief Executive, NHS Institute for Innovation and Improvement
Case Study 09 Progressing Patient Safety in South West Strategic Health Authority

Following the publication of Safety First last year, the South West SHA reviewed its approach to patient safety and will publish a strategy that will detail how the SHA will provide leadership and direction to the NHS; building on the current examples of excellent practice and setting the ambition that all NHS organisations in the South West will be among the best in the country. Chief Executive of South West SHA, Sir Ian Carruthers OBE, explains:

Patient safety will become one of the key priorities for all organisations in our region, with leadership from Boards, managers and clinicians a prerequisite.

Patient Safety Networks have been established supporting the identification and transfer of good practice and innovation. Four NHS trusts (Musgrove Park in Taunton, working with Torbay Hospital in Devon, and Southmead Hospital, working with the Bristol Royal Infirmary) are part of the Safer Patients Initiative (SPI) from The Health Foundation and are working in partnership to improve safety in areas such as critical care, medicines management and infection control, and are establishing an overall approach to patient safety.

The SPI has led to more awareness of error within the participating organisations. For example:

• Patient safety indicators such as hospital standard mortality rates are being reported regularly to the Board at United Bristol Healthcare NHS Trust and the Trust has committed to publishing any investigation it undertakes into serious harm.

• In Taunton, the introduction of hand hygiene audits in the intensive care unit has led to an improvement in hand hygiene compliance and the elimination for the past few months of MRSA from the unit.

• Paediatric services in Bristol are working with the Boston Children’s Hospital in the USA on managing of human factors and in simulated paediatric medicine to reduce errors.

• In October 2007, the Cornwall and the Isles of Scilly PCT launched its collaborative approach to patient safety with the aim of improving the quality of local health and social care services. By tackling the problems on a multi-agency basis, it will maximise the impact on patient safety. All NHS organisations in the area, together with the local County Council, have signed up to a strategy that pledges improvements in patient safety covering prevention and infection control, reduction in medication errors, reduction in slips, trips and falls, reducing accidents when using medical equipment, and treating patients with respect and dignity.

• We have begun a joint project with the Association of British Pharmaceutical Industry concerning medication safety in primary care.

“Our ambition is to ensure that across the South West there is a year-on-year reduction in harm arising from medical and clinical errors with, for example, a planned reduction of 25 per cent in errors from the use of medical equipment year-on-year from 2007/08.”

Sir Ian Carruthers OBE, Chief Executive, South West SHA
Case Study 10: National Patient Safety Agency – design for patient safety

The Department of Health report, *Design for patient safety* (2003), acknowledged that the use of design in safety critical industries had produced significant improvements in safety, quality and efficiency. The report recommended that a similar approach be taken within healthcare. The NPSA has subsequently published a series of reports that look at how design can be used to improve patient safety.

Effective design can deliver products, services, processes and environments that are intuitive, simple to understand, simple to use, convenient and comfortable, and consequently less likely to lead to errors.

**Medication packaging**

*Design for Patient Safety: Information design for patient safety* was the result of a design research collaboration between the NPSA and the Helen Hamlyn Research Centre at the Royal College of Art, London.

The report shows how graphic design on medicine packaging can enhance patient safety, and details best practice based on established guidelines. It is aimed at packaging designers and pharmaceutical companies, but is also of interest to those in the NHS who regulate and purchase medication.

**Future ambulances**

Working with the Helen Hamlyn Research Centre at the Royal College of Art, *Design for patient safety: Future ambulances*, aims to encourage the standardisation of ambulances and their equipment across England and Wales.

The report is the result of a year-long study initiated to investigate how the safety of patients and ambulance staff could be improved through better design of vehicles and equipment.

**Dispensed medicines and the dispensing environment**

These two booklets focus on using design to help reduce the number of errors made when medicines are dispensed and used.

*Design for patient safety: A guide to the design of dispensed medicines* looks at some key elements of the labelling and presentation of a dispensed medicine, including setting up the label, applying the label, dispensing bags and aiding the use of medicines.

*Design for patient safety: A guide to the design of the dispensing environment* looks at each stage of the dispensing process to highlight how implementing improved design can make the process as safe as possible.

All the documents in the *Design for patient safety* series can be downloaded from www.npsa.nhs.uk/patientsafety/improvingpatientsafety/design
All NHS organisations should develop and implement local initiatives to promote greater openness with patients and their families when things go wrong and to provide required support.

Introduction
Current frameworks and legislative levers provide recommendations that encourage healthcare providers to communicate with their clients. National level guidance and programmes exist to help NHS organisations and staff to achieve this recommendation.

Along with the NPSA’s guidance on Being Open, the Department of Health’s current work on the reform of complaints and the NHS Redress Scheme seek to encourage the development of local initiatives to promote greater openness with patients and their families when things go wrong and to provide the required support.

Achievements and Progress
The Department of Health has undertaken a review of the legislative mechanisms and guidance outlined above and has identified a common approach and consistency of language applied to offering apology, expressing remorse, and providing explanations to patients, families and their carers.

In conjunction with this, an analysis of SABS data was undertaken (recorded actions by NHS organisations as at January 2007 and August 2007) to assess how many healthcare organisations in England had completed their Being Open policy. This quantitative self-assessment measure from each NHS trust on the progress it had made, demonstrated that the NHS is still developing policy in this area. The NPSA also commissioned a qualitative evaluation of the implementation of the Being Open policy and training from York University.

Most of the guidance documents that address the issue of communication with patients and their families when things go wrong, confirm that healthcare staff should apologise for the incident and offer an explanation. Despite the existence of this guidance to healthcare staff from the Department of Health, their professional organisations and defence organisations, apologies do not often occur when communicating with patients and relatives at these difficult times.

4 For example, the Compensation Act 2006, Ch 9, Sec 2; the Compensation Act 2006 and the Private and Voluntary Health Care (England) Regulations 2001 for independent healthcare, Part III Conduct of healthcare establishments and agencies, Sec 20 Guidance for health care professionals.

5 The Safety Alert Broadcast System (SABS) is the Department of Health’s website and email system by which safety alerts are distributing to the NHS, and trust compliance is recorded.
The way forward

The next stage is a review to consider what barriers in the NHS are preventing open communication with patients and how to overcome these in light of successful strategies used internationally.

This work is currently being commissioned.
Recommendation 13

The active involvement of patients and their families should be promoted by establishing a national network of patient champions who will work in partnership with NHS organisations and other key players to improve patient safety; the network should also have strong links with WHO World Alliance for Patient Safety’s ‘Patients for Patient Safety’ initiative.

Introduction
What constitutes a patient champion? The common feature is that it is people who want to actively participate in improving patient safety in health services. Patients ‘clearly see medical harm and patient safety holistically. In this sense, the topics they want to cover for the future relate both to learning and accountability.’

Achievements and Progress
This year, the NPSA has worked with many stakeholders to develop a framework for the patient champion network. We consulted with organisations such as Action against Medical Accidents (AvMA), The Parents Association, Medical Self-Harm Network, Sufferers of Iatrogenic Neglect, Royal Colleges, NHS trusts, the Welsh Assembly Government, the Department of Health and many others to canvas the widest possible range of opinions.

As a result, in October 2007, the NPSA invited expressions of interest from organisations skilled in developing networks, partnership development and working with the public to help establish a formal network of patient champions in England.

The first steps will be to bring champions and the newly formed PSATs together to work to identify and develop work programmes in their areas.

Champions will be encouraged to:

- explore the gap in reporting rates and work with staff to improve reporting;
- develop patient safety initiatives locally;
- participate with the various boards, groups and committees such as LINKs to ensure patient safety is focused on and made a priority.

---

6 Patients for Patient Safety - Report on First Year.
In its preliminary work with AvMA, the NPSA has identified that changing practice by simply introducing a network of champions is not sufficient. Both NHS staff and patients need to be supported in coming together to explore and support patient safety improvements and to contribute to the shape and design of safer patient care.

The way forward

The first patient safety champion workshop will be held in February 2008.

Close links are being developed with the WHO World Alliance for Patient Safety networks.

Case Study 11
AvMA and Patient Safety

AvMA’s Chief Executive, Peter Walsh is a member of the Patient Safety Forum, the only member from a patients’ organisation. AvMA deals with over 4,000 enquiries each year from patients and families affected by medical accidents.

During the year, AvMA has continued to develop the Patients for Patient Safety project, which it manages in partnership with the NPSA. The project recruits, trains and supports patients and members of the public who are interested in working with the NHS to improve safety.

AvMA has been able to draw on its extensive contacts with people affected by medical harm and links with other patient groups to develop this network. As part of the project, the project managers have worked with two separate NHS trusts to assist them in involving patients and carers and identifying barriers to good practice.

Learning from the project has fed directly into the plans for the development of a network of patient safety champions.

AvMA has continued to use its unique position, straddling both patient safety and access to justice work, to influence policy in both areas. An example is the work achieved as part of the NHS Redress Scheme and its individual casework with clients.

The last word from a patient

“You’ve already been given the Warfarin long before you even know what day it is. I was in a coma for a week so, by that time I was already on Warfarin.”

“When I had my first stroke and they give you the tablets...I never knew I was supposed to take them all the time. No one discussed it with me.”

7 Preventing Patient Safety Incidents with Anticoagulants: A Patient Workshop, NPSA 2005
Recommendation 14

This recommendation contained a set of seven suggestions for moving forward on the patient safety agenda. The response below represents an overview of the work of the Patient Safety Forum to date and its planned objectives moving forward.

Introduction

The Patient Safety Forum has focused its attention on the key activities identified in the recommendations in Safety First – the redesign of the NRLS, immediate action to set up the PSATs, an early pilot on NICE effectively delivering technical solutions, and the development of a campaign strategy to embed patient safety in the NHS.

The imperative to improve patient safety has become a central component of the Health Reform Agenda, with better clarification of roles and responsibilities. This means that greater collaboration between all organisations involved in healthcare needs to be pursued, and the development of an overall plan is required.

This report has explained the outcomes achieved individually and collectively by the healthcare organisations most involved in developing patient safety initiatives during the past year. Particularly evident are the linking threads between the responses and the opportunities that have been identified to establish collaborative ways of working.
The way forward

Leadership and the implementation of practical solutions will form the basis of the way forward; driven by the imperatives of better practices, as outlined in this report.

The challenge set out in Safety First identified the need for all staff in all organisations involved in healthcare to be more aware of their patients’ safety and to work together to make the improvements necessary.

Success will be realised when the numbers of avoidable deaths are reduced, when the numbers of serious incidents are minimised and when patients feel safer whilst undergoing care.
Case Study 12: The Health Foundation – working to improve patient safety

The Health Foundation is an independent charitable organisation working to improve the quality of healthcare across the UK and beyond. Chief Executive, Stephen Thornton, outlines the Foundation’s achievements in improving patient safety throughout 2007:

The Health Foundation is investing £10million in its Safer Patients Initiative (SPI). Through this initiative, 24 hospitals across the UK are finding ways of making care safer for patients. In collaboration with the IHI, we are providing hospitals with technical expertise on change management and patient safety improvement plus training in measurement.

The initiative has seen good results. The four hospitals selected in the first phase (which began in October 2004) have all halved the number of adverse incidents occurring in their organisations in the first two years. Now three years into this four-year initiative, all four hospitals are optimistic about the safety improvements that can be achieved with the right support, skills and leadership throughout the organisation.

In November 2006, the second phase was launched, with 10 further awards made to 10 pairs of hospitals. This phase lasts for 20 months and we hope that having hospitals pair up will accelerate the improvements and provide mutual support. Each hospital is testing out what works to improve patient safety in three clinical settings: on the wards; before, during and after operations; and in critical care.

Measurement is central to SPI. There are 40 different measures being used to monitor progress in each hospital. Staff use run charts to monitor mortality, surgical site infections, blood stream infections, ventilator acquired pneumonia, crash calls and blood sugar measures. These statistics all go into a rigorous monthly report. The 20 hospitals selected to take part in phase two are now one year into this work. All are making progress but are finding it a challenge to implement every one of the 40 measures.

The first phase of SPI is being evaluated by the Universities of Birmingham, Leicester and Warwick. In addition, we have commissioned the ‘Journey to Safety’ research programme conducted by Professor Charles Vincent. This research will examine the nature and characteristics of high reliability in healthcare and identify the key practical steps that units and organisations take to achieve high reliability and map the journey to safety.

We want to make sure that SPI isn’t a one-off project. We are committed to sharing what we learn.
Case Study 13: A Charter for the Safety of Patients

The Charter for the safety of patients was launched at a meeting on 22 February 2007, that included the Minister of State for Health, the Chief Medical Officer, the leaders of key professional and public bodies, as well as representatives from both the NHS and independent healthcare organisations. Demonstrations of this commitment will be shared at a future meeting of those who signed the Charter and thereafter passed to the Patient Safety Forum.

The Charter reads:
We, the undersigned, have separate but linked responsibilities for key aspects of the provision of healthcare and recognise that:

• We must offer the leadership which will accelerate change. This will call for close cooperation, energy, passion and clear direction.

• A culture of commitment to safe care must be fostered and embraced by all those involved in providing care so that protecting patients from avoidable harm becomes an accepted feature of ‘the way things are done around here’.

• Safety is at the core of clinical practice and patient care; we all have a role to play in ensuring that the safety of care is continuously improved.

• We need to revitalise our approaches for improving the safety of care, to eliminate suffering, avoidable harm and care of poor quality.

Accordingly, we will make this public commitment afresh, that our organisations will:

• Encourage renewed engagement, contributions and challenge from professionals, from other health service staff and organisations, and from patients and the public to support us in fulfilling these commitments.

• Ensure that the safety of patients is a key priority in our work – in practice as well as words.

• Work closely together on programmes and initiatives to contribute to improvements in the safety of care that will benefit patients.

• Exchange information, data and intelligence actively when it is appropriate to do so in the interests of the safety of patients.

• If responsible for providing healthcare, report adverse events, when things go wrong, and ‘near misses’ so that lessons may be learned.

• Lead the creation of a culture and environment which promotes individual, organisation, and system improvement and learning, to prevent harm.

“The safety of patients must be at the forefront of the agenda of healthcare. Safety cannot ever be allowed to play second fiddle to other objectives that may emerge from time to time. It is the first objective. I very much welcome the key contribution that Safety First has made in reinforcing this fundamental principle. I was pleased to be joined earlier this year by the leaders of over 30 organisations in signing the Charter. Together we have made this public commitment on the priority we give to safety as a central component of our work.”

Professor Sir Ian Kennedy,
Chairman, Healthcare Commission

“Patient safety must always be the number one priority for all NHS staff and organisations. The achievements in the year since Safety First was published represent considerable progress. But we must continue to view patient safety as a long term campaign if we are to make lasting changes and improve the care and safety of patients in NHS care. Over the coming year we all must redouble our efforts to pursue the goals of Safety First to ensure patient safety is embedded in the NHS at all levels for all patients. The NPSA will take a lead in supporting NHS organisations to improve patient care and improve patient safety.”

Lord Patel, Chairman, NPSA
Glossary

AvMA  Action against Medical Accidents
GMC  General Medical Council
HSMR  Hospital Standardised Mortality Ratio
IHl  Institute for Healthcare Improvement (USA)
LIPS  Leading Improvement in Patient Safety
MHRA  Medicines and Healthcare products Regulatory Agency
MRSA  Methicillin-resistant Staphylococcus aureus
NHSIII  NHS Institute for Innovation and Improvement
NICE  National Institute for Health and Clinical Excellence
NPSA  National Patient Safety Agency
NRLS  National Reporting and Learning System
PCT  Primary Care Trust
PSAT  Patient Safety Action Team
SABS  Safety Alert Broadcast System
SHA  Strategic Health Authority
SPI  Safety Patients Initiative
SUI  Serious untoward incident
WHO  World Health Organization

The following organisations have contributed to this report:

Academy of Medical Royal Colleges
AvMA
Department of Health
General Medical Council
Healthcare Commission
Lincolnshire Primary Care Trust
Luton and Dunstable Hospitals NHS Foundation Trust
Medicines and Healthcare products Regulatory Agency
Monitor
National Institute for Health and Clinical Excellence
National Patient Safety Agency
NHS Institute for Innovation and Improvement
South West Strategic Health Authority
The Health Foundation
Patient Safety Forum Members

Stuart Bell
Chair Executive, South London and Maudsley NHS trust

Professor Dame Carol Black
Chair, Academy of Medical Royal Colleges

Maura Buchanan
President, Royal College of Nursing

Dr Harry Burns
Chief Medical Officer – Scotland, Scottish Government

Sir Ian Carruthers OBE
Chief Executive, NHS South West

Sir Graeme Catto
President, General Medical Council

Wendy Chatham
Director of Quality, Standards and Safety Improvement, Welsh Assembly Government

Stephen Collier
Chairman, Independent Healthcare Advisory Services

Professor Bernard Crump
Chief Executive Officer, NHS Institute for Innovation and Improvement

Lord Darzi
Parliamentary Under Secretary of State, Department of Health

Andrew Dillon CBE
Chief Executive, National Institute for Health and Clinical Excellence

Sir Liam Donaldson
Chief Medical Officer – England, Department of Health

Martin Hetcher
Chief Executive, National Patient Safety Agency

Dr Tony Jewell
Chief Medical Officer – Wales, Welsh Assembly Government

Professor Sir Ian Kennedy
Chairman, Healthcare Commission

Dr Michael McBride
Chief Medical Officer – Northern Ireland, Department of Health, Social Services & Public Safety

Dr Martin McShane
Director of strategy Planning & Health Outcomes, Lincolshire Primary Care Trust

Dame Gill Morgan
Unid executive, NHS Confederation

Dr William Moyes
Executive Chairman, Monitor

Joe Neeanor
Patient safety & investigations, Department of Health

David Nicholson CBE
Chief Executive, National Health Service

Hemant Patel
President, Royal Pharmaceutical Society of Great Britain

Lord Patel
Chairman, National Patient Safety Agency

Stephen Ramsden
Chief Executive, Luton and Dunstable Hospital NHS Foundation Trust

Dr Rashmi Shukla
Director of Public Health, NHS West Midlands Department of Health (Government Office for West Midlands)

Stephen Thornton
Chief Executive, The Health Foundation

Stephen Walker CBE
Chief Executive, NHS Litigation Authority

Peter Walsh
Chief Executive, Action against Medical Accidents

Professor Kent Woods
Chief Executive, Medicines and Healthcare products Regulatory Agency

To order further copies of Safety First: One Year On, call the NHS response line on 08701 555 455, quoting NPSA reference 0688.
SAFETY FIRST: ONE YEAR ON

Outlining progress on the recommendations of Safety First

December 2007

The National Patient Safety Agency
4 - 8 Maple Street
London
W1T 5HD
T  020 7927 9500
F  020 7927 9501

© National Patient Safety Agency 2007. Copyright and other intellectual property rights in this material belong to the NPSA and all rights are reserved. The NPSA authorises healthcare organisations to reproduce this material for educational and non-commercial use.

www.npsa.nhs.uk