action against medical accidents

for patient safety and justice

1 October 2012

Dear Mr Nicholson and Members of the National Quality Board

Thank you for the opportunity to comment on your plans for ensuring quality in the new Health System. Action against Medical Accidents (AvMA) is the specialist patients' charity which is specifically focussed on patient safety and supporting people who have been affected by medical accidents ('patient safety incidents'). We have over 30 years' experience and have been key partners of the Department of Health and others such as the National Patient Safety Agency and individual NHS bodies in raising awareness and improving patient safety. Until it was absorbed into the NQB we were active members of the National Patient Safety Forum, bringing a well informed patient perspective. We were core participants in the Mid Staffordshire NHS Foundation Trust Public Inquiry, and our work brings us into contact with people affected with things going wrong in healthcare every day, providing us with a wealth of insight not only into their experience, but into what is going wrong and how the system learns from mistakes. We have restricted our comments to those areas where we think we can most add value to the plans.

Quality Surveillance Groups (QSGs)

We welcome the plans for establishment of QSGs. Done well, they have the potential to be a valuable safeguard for patient safety and quality. However, we feel that much more thought needs to be given to the status and role of them if they are to be effective. They need to be a completely different kind of 'body' than the previous "Patient Safety Action Teams". We are particularly concerned about the current vagueness about how QSGs will operate. For example, the following is a quote from the report:

"No longer will there be a 'system manager' in the form of a Strategic Health Authority on the scene to hold the ring in the event of a failure situation. Rather, the system will need to manage itself – the parties will need to collectively determine what actions should be taken forward and how they should be coordinated." (Page 49). This vagueness could be a recipe for confusion and further disasters like Mid Staffordshire.

We have the following recommendations concerning QSGs:

- They need a formal status and clearer identity. The relevant statutory bodies should be formally required to take part in and co-operate with them.

- There must be clarity and consistency over which organisation will 'hold the ring' for ensuring actions to protect patients are taken

- They need to be sufficiently at arm's length from the local commissioning and providing organisations to be able to take an independent, objective view

- They need to have sufficient 'clout' to make local organisations take them seriously

- Their work needs to be open and transparent, and they should be visible and easy to contact.

- They should involve representatives of patients as equal partners (not simply have a lay rep as a token member)

We welcome the intention of including local Healthwatch in the team's membership. However, more thought and resources need to be given as to how to train and support members of local Healthwatch to fulfil this role. We recommend that rather than 're-inventing the wheel' the work which AvMA has done in partnership with the National Patient Safety Agency in establishing a 'patients for patient safety' network and training and supporting ' patient safety champions' is drawn upon. AvMA maintains the 'patients for patient safety' network, which includes approximately 3,000 members of the public with a strong interest in patient safety. Learning from the work with the NPSA and the experience of patient safety 'champions' in trying to work with Patient Safety Action Teams (and vice versa) can be put to good use. AvMA is also in the process of producing toolkits for lay representatives who are involved in monitoring work on patient safety within the NHS. AvMA would be pleased to be a strategic partner of Healthwatch, the QSGs and the National Quality Board in supporting lay people in monitoring and surveillance of quality and safety in the NHS.

<u>The National Quality Board (NQB)</u>

The NQB plays a vitally important role in overseeing how the whole system is working. It brings together all the key national statutory bodies. We suggest that from next year it should also include National Healthwatch in its membership to supplement the individual lay representation already present. However, we believe that membership of the NQB should also include AvMA, as the only national patient's organisation specifically specialising in patient safety. AvMA were, we understand, a valued member

of the National Patient Safety Forum, bringing this particular expertise and national overview.

"Open and honest co-operation"

We believe the QSB is right to place such emphasis on the need for a culture of open and honest collaboration. However just saying this is not enough. The NQB should acknowledge that ensuring openness with patients when things go wrong and protecting and supporting staff who want to rise concerns (whistleblowers) requires giving these issues equal status as any other 'Essential Standard of Quality and Safety". Failure to do so is likely to perpetuate the current unsatisfactory culture towards these issues. Placing them in a statutorily regulated footing would help change the current culture and provide the possibility of regulatory action if required.

Outcomes Framework

Whilst there are many merits of an outcomes based framework for monitoring quality in the NHS, a slightly different approach is required when it comes to patient safety. Whilst the overall aim must of course be to reduce the number of avoidable incidents which cause harm to patients, the system needs to be much more responsive to indicators that can alert it to possible serious failures before they result in significant harm to patients. It is therefore necessary to take process very seriously. An example would be failure to implement patient safety alerts by the given deadline. Serious failures in implementing them should result in action from the QSG or the CQC. As discussed above, a failure to promote an open and honest culture of co-operation with regard to patients or to whistleblowers are other examples.

We hope you find these comments helpful. We would welcome the opportunity to explore these ideas with you in more detail.

Yours sincerely

Peter Walsh

Peter Walsh
Chief Executive