WELCOME TO

The NHS Patient Safety Conference 2022: Breaking a culture of defensiveness

Check Out Our Agenda Here...

8th July 2022- 08:00am – 15:30pm – Mercure Manchester Piccadilly Hotel

Conference hosted by Convenzis Group Limited

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The NHS Patient Safety Conference 2022

SCAN ME

8th July 2022- 08:00am – 15:30pm – Mercure Manchester Piccadilly Hotel

Conference hosted by Convenzis Group Limited

The NHS Patient Safety Conference 2022:
Breaking a culture of defensiveness

Event Chair – Opening Address

Jane Walsh

Senior Improvement Advisor
Advancing Quality Alliance
(Aqua)

The NHS Patient Safety Conference 2022:
Breaking a culture of defensiveness

SPEAKING NOW

Helen Hughes

CEO
Patient Safety Learning

I will be discussing…

"Mind the Implementation Gap: The Persistence of avoidable harm in the NHS"

The NHS Patient Safety Conference:
Breaking a culture of defensiveness

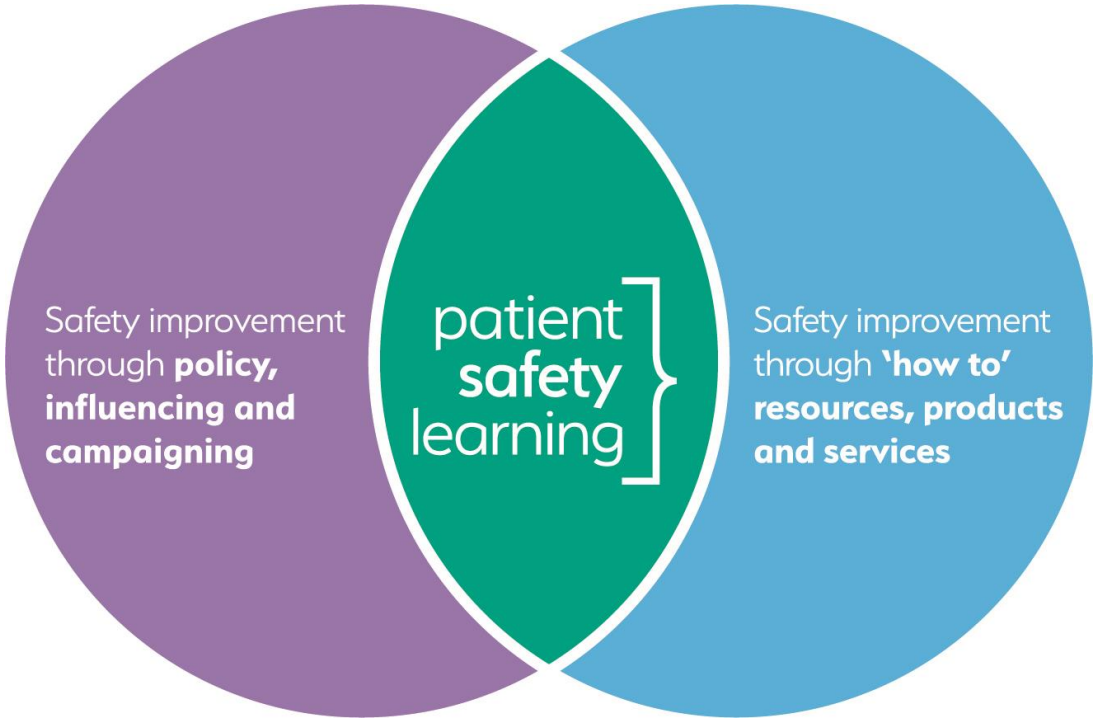
Mind the implementation gap: The persistence of avoidable harm in the NHS

Helen Hughes
Chief Executive, Patient Safety Learning

patient safety learning

An independent charity for patient safety

Patient Safety Learning is a charity and independent voice for transformational change in how health and social care organisations think and act in regard to patient safety.



Scale of avoidable harm in healthcare

Patients want safe and effective care and assume that patient safety is a priority. Yet despite the efforts and good work of many people to address patient safety issues, unsafe care continues to persist.

11,000	avoidable deaths annually due to safety concerns (UK)
3 million	deaths each year worldwide as a result of unsafe care.
15%	of healthcare costs attributable to unsafe care

Have we normalised an unsafe system?

Breaking a culture of defensiveness

"To err is human, to cover up is unforgiveable and to fail to learn is inexcusable" - Sir Liam Donaldson

"The single greatest impediment to error prevention in the medical industry is…that we punish people for making mistakes" - Professor Lucian Leape

Despite a range of international and national initiatives aimed at reducing avoidable harm, patient safety remains a persistent, wide-scale problem.

Why does avoidable harm persist?

We do not operate as an effective safety management system with patient safety at its core purpose

- Safety is one priority of many
- Few safety standards
- Not designing safe systems
- Blame culture and fear
- Patients not engaged
- Lack of leadership
- Failure to learn and act

We need to design for safety, not just address harm

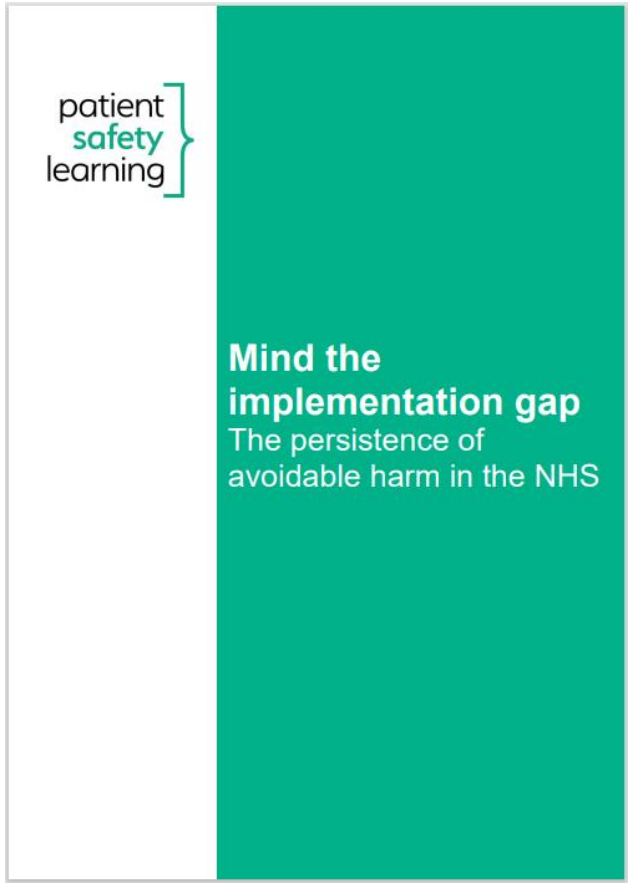
- Safety is a core purpose
- Leadership commitment to safety
- Safety standards
- Design safe systems
- Safety comparison data to drive out variation
- Competency framework for all staff
- Patient safety and human factors expertise
- Engage patients
- Learn from errors and act
- A Just Culture; psychologically safe

patient safety learning

What is the implementation gap?

The difference between what we know improves patient safety and what is done in practice. The report highlights this in relation to six specific policy areas:

1. Public inquiries and reviews
2. Healthcare Safety Investigation Branch reports
3. Prevention of Future Deaths reports
4. When patients and families take legal action
5. Patient complaints
6. Incident reports



Common underlying themes

Absence of a systemic and joined-up approach

- Inquiries/reviews which raise similar issues dealt with in isolation.

Poor systems for shared learning and acting on that learning

- Lack of effective means by which to share insights and recommendations.

Lack of system oversight, monitoring, and evaluation

- Lack follow-up/assessment of effectiveness. e.g. HSIB and PFD recommendations

Unclear patient safety leadership

- Fragmented national environment, lack of a central point of coordination.

Bridging the implementation gap

Patient safety needs to be core to the purpose of healthcare.

- Should apply to all parts of the system, including newly statutory Integrated Care Systems.
- Needs to be a system-wide debate on how we can reshape our approach to learning and safety improvement.
- The report also sets out six specific recommendations in regards to each of the areas if the implementation gap outlined in this report.

Recommendations for action

- System-wide commitment and resources, with effective and transparent performance monitoring to ensure that Inquiry and Litigation recommendations translate into action and improvement:
  - Inquiries, HSIB investigations, NHSE/I and NHS Resolution litigation, MRHA Yellow Card
  - Coroner's PFD system with reports to be easily accessed
  - Improved process for identifying the causal factors of unsafe care
  - NHS Complaints Standards, public transparent reporting on the rollout, allowing for consistent monitoring and comparison
  - New PSIRF and changes to the Yellow Card scheme have a core focus on learning for action and improvement

Foundations for patient safety

Patient safety is core to the purpose of healthcare

- Rather than one priority competing against other priorities

We need to design for safety

- Standards for safe care
- Healthcare to become a compassionate high reliability system

Self assessment and accreditation

The value of organisational patient safety standards

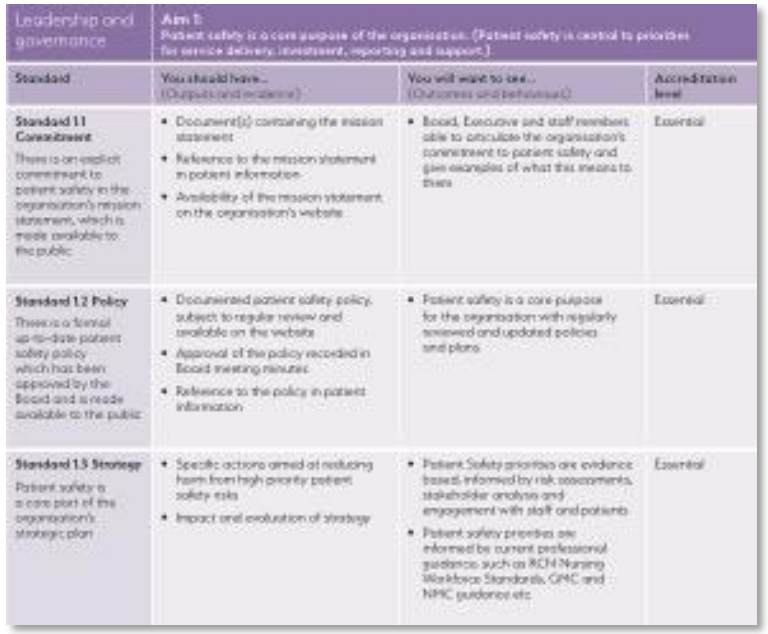
Assess their strengths and weaknesses against organisational standards for safety

Create a vision and set of goals for safety development

Evaluate their performance and impact

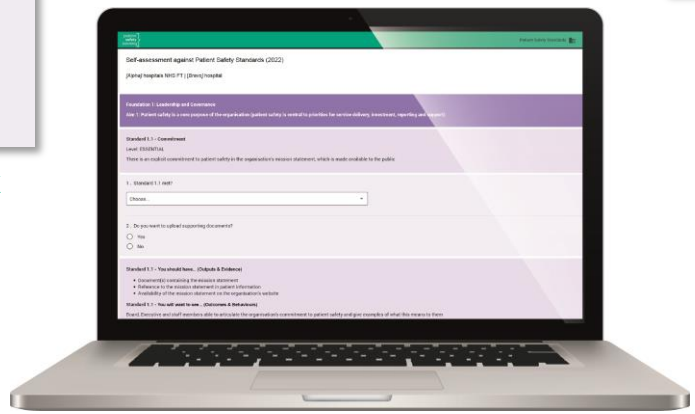
Develop and deliver safety improvement and implementation plans

...and tools: Standards to help deliver evidence-based outputs, outcomes & behaviours



'What good looks like' practical guidance workbook

Online self-assessment toolkit



Quick reference booklet

Blueprint for Action: Foundations and Aims

Leadership and governance

1. Patient safety is a core purpose
2. Patient safety is embedded in governance
3. Organisation has a patient safety plan
4. New services are designed for safety
5. System leadership
6. Organisational leadership for patient safety

Culture

7. Patient safety culture tackles blame and fear
8. Promotes patient safety improvement
9. Role of HR

Shared learning

10. Learning goals for improving patient safety
11. Learning from near misses
12. Learning from investigations
13. Learning from feedback and complaints
14. Learning from others
15. Shares learning with others

Professionalisation of patient safety

16. All staff are suitably qualified and experienced
17. Specialist skills in patient safety and human factors

Patient engagement

18. Commitment to patient engagement
19. Organisational systems for engaging with patients
20. Patient engagement in their own care
21. Patient engagement if things go wrong
22. Patient engagement for safer care

Data and insight

23. Metrics and data to measure and manage patient safety

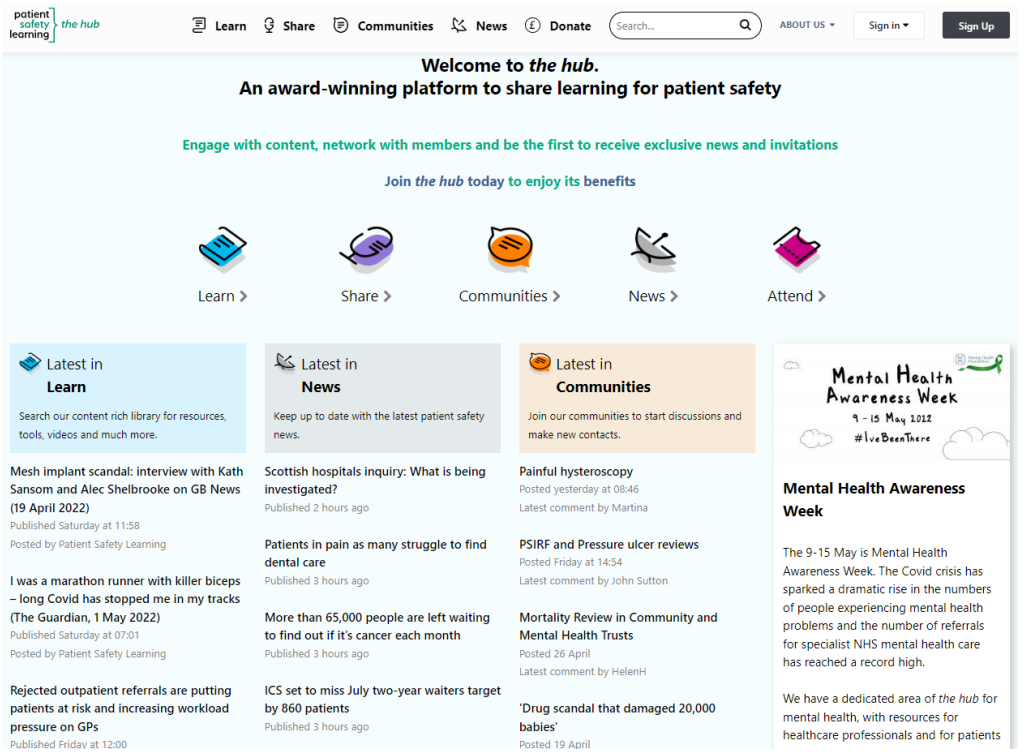
Delivery of patient safety services

24. Services are delivered safely
25. Workforce planning
26. Workforce deployment

Leadership and governance	**Aim 1:** **Patient safety is a core purpose of the organisation. (Patient safety is central to priorities for service delivery, investment, reporting and support.)**		
Standard	**You should have...** (Outputs and evidence)	**You will want to see...** (Outcomes and behaviours)	**Accreditation level**
Standard 1.1 Commitment There is an explicit commitment to patient safety in the organisation's mission statement, which is made available to the public	• Document(s) containing the mission statement • Reference to the mission statement in patient information • Availability of the mission statement on the organisation's website	• Board, Executive and staff members able to articulate the organisation's commitment to patient safety and give examples of what this means to them	Essential
Standard 1.2 Policy There is a formal up-to-date patient safety policy which has been approved by the Board and is made available to the public	• Documented patient safety policy, subject to regular review and available on the website • Approval of the policy recorded in Board meeting minutes • Reference to the policy in patient information	• Patient safety is a core purpose for the organisation with regularly reviewed and updated policies and plans	Essential

the hub *www.pslhub.org*

- Sharing knowledge for learning and action through our free patient safety platform
- Publishing and promoting high quality content that can be shared to improve patient safety
- Promoting patient safety good practice and policy



patient safety learning } *the hub*

Two years old – making an even greater impact

What is *the hub*?

Launched in 2019, it's our award winning resource platform that consists of:

LEARN: a knowledge library
COMMUNITY: message boards
NEWS: latest patient safety stories
ATTEND: patient safety events

Membership is free – register at:
www.pslhub.org

2,600 members

74 countries

791,000 page views

980 organisations

5,000 learn posts

396,000 site visits

800
Community page visits per week

3,300
Learn page visits per week

Staff from **80%** of NHS Trusts in England are members

Number of countries our visitors are from:

207

14,500
people visited the website over **100** times

10,000+
knowledge resources on *the hub*

3.2 million
The number of times a hub landing page appeared in a Google search.

Top social # referrers

- **49,000** Twitter
- **15,000** Facebook
- **7,000** Linkedin
- **2,000** Weebly

Members include:

- Patient safety & quality improvement experts
- Health & care organisational directors
- Clinicians & business managers
- Frontline health & care workers
- Patients & service users
- Campaigners
- Health & care regulators
- Health & care suppliers
- Media & event organisers
- Members of device & medicine safety networks
- Commissioners

Work with us to create a patient-safe future

- Learn and share
- Join a community
- Become a topic expert
- Share your experiences
- Patient Safety: a social movement

Email: helen@patientsafetylearning.org
Website: www.patientsafetylearning.org
Twitter: @ptsafetylearn
LinkedIn: Patient Safety Learning

The NHS Patient Safety Conference 2022:
Breaking a culture of defensiveness

SPEAKING NOW

Dr Sarah Kay

Joint Clinical Governance Medical Lead
Covid Clinical Assessment Service, part of the Covid-19 Response Service hosted by South Central Ambulance Service

I will be discussing…

"The metrics that matter: Judging the quality & safety of remote consultations"

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NHS Foundation Trust

The metrics that matter
Judging quality and safety of remote consultations

The NHS Patient Safety Conference: Breaking a culture of defensiveness

8th June 2022

Dr Sarah Kay – Joint Clinical Governance Medical Lead, Covid-19 Clinical Assessment Service (CCAS-01)

Dr Kathy Smith – GP and Auditor (CCAS-01)

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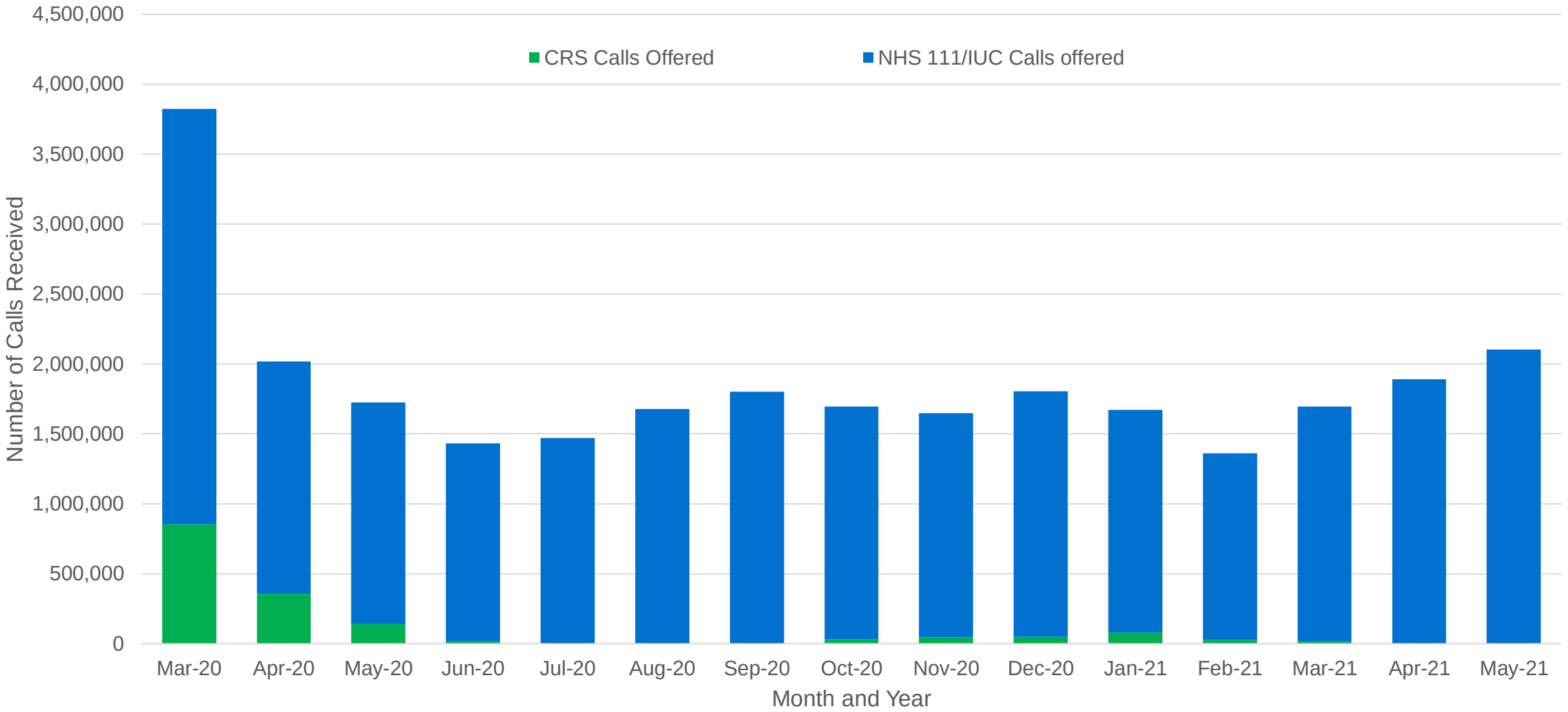
Aims :

- Understand: What was the CCAS?
- Awareness of the unique challenges faced - operational and clinical
- Audit and Feedback Programme
- Recommendations

Call demand on NHS 111/IUC with additional CRS data, March 2020 – May 2021



Source: NHS 111 MDS Time Series to March 2021, IUCADC including NHS 111 to March 2022 and IUC CRS data from Feb 2020 to Mar 2022

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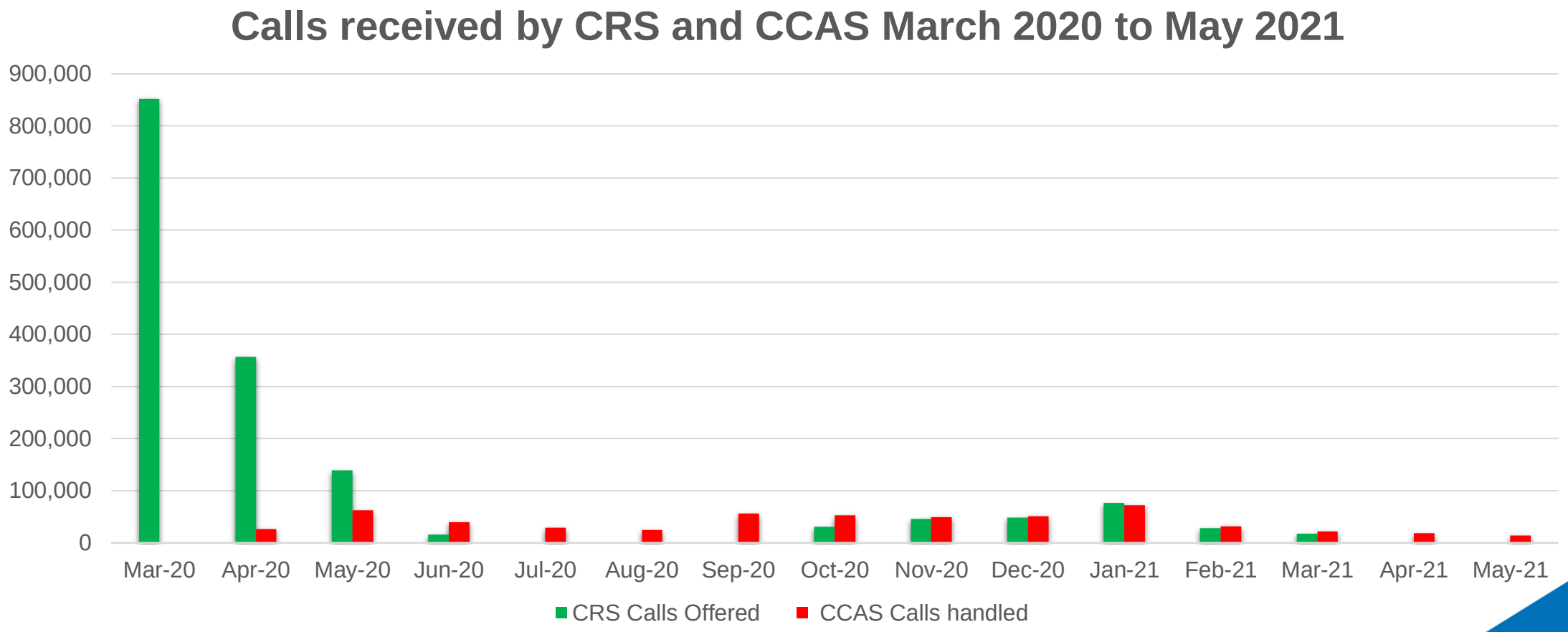
A closer look at the numbers..



Source: IUC CRS data from Feb 2020 to Mar 2022

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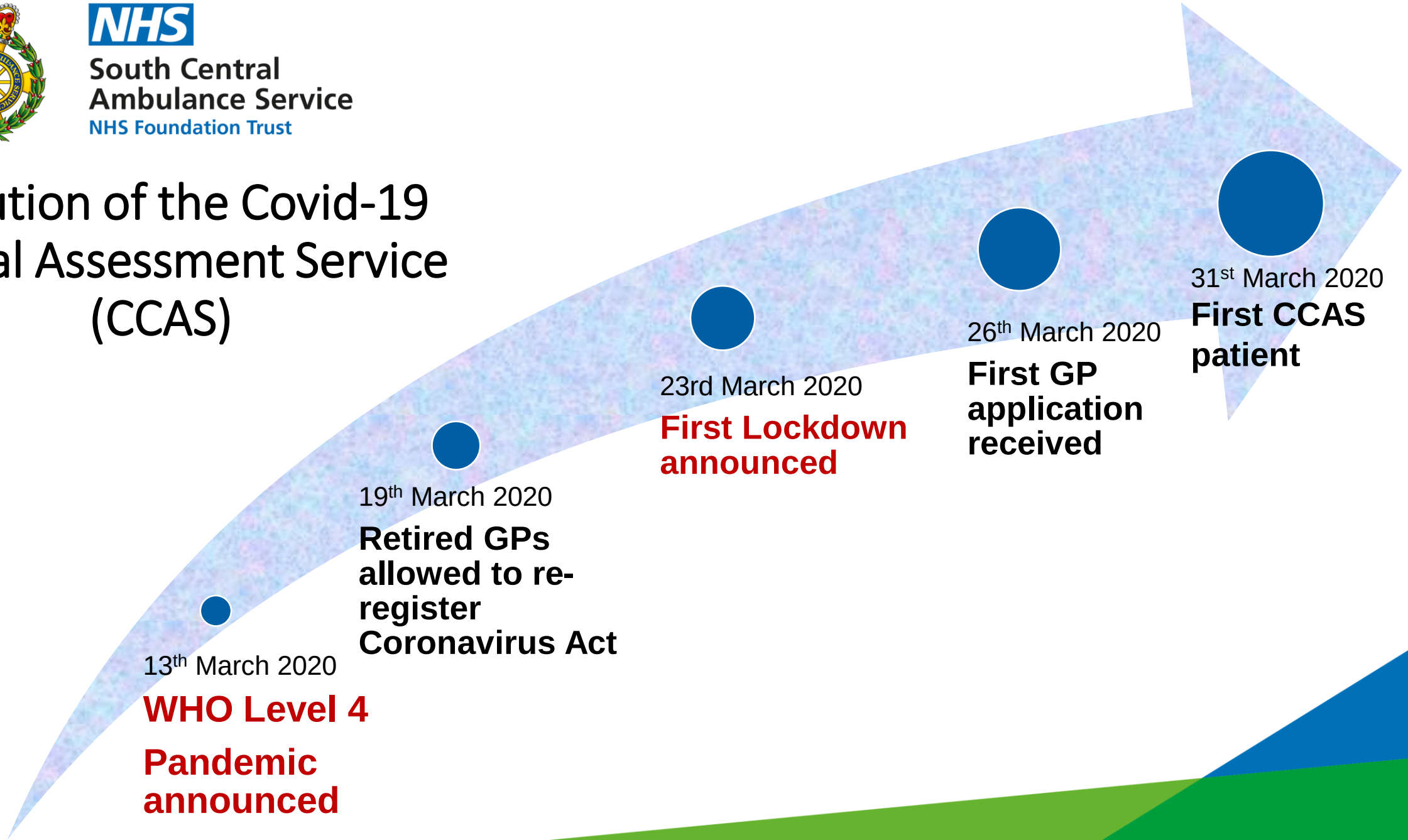
Evolution of the Covid-19 Clinical Assessment Service (CCAS)



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March 2020

- First GPs onboarded to CCAS
- Laptops sent out to GPs

April 2020

- First peak in COVID-19 cases
- First Nightingale Hospital launched in London
- NICE Guideline [NG165] COVID-19 rapid guideline published

May 2020

- 24 hr service launched
- Coronavirus (COVID-19) Breathlessness Triage Support Tool guidance published (NHS Digital)

June 2020

- RECAP and Principle trial patient recruitment via CCAS

July – Aug 2020

- Video consultation tool launched
- Electronic Prescribing facility

Sep - Nov 2020

- Second peak in COVID cases
- Second National Lockdown
- SMS messaging launched

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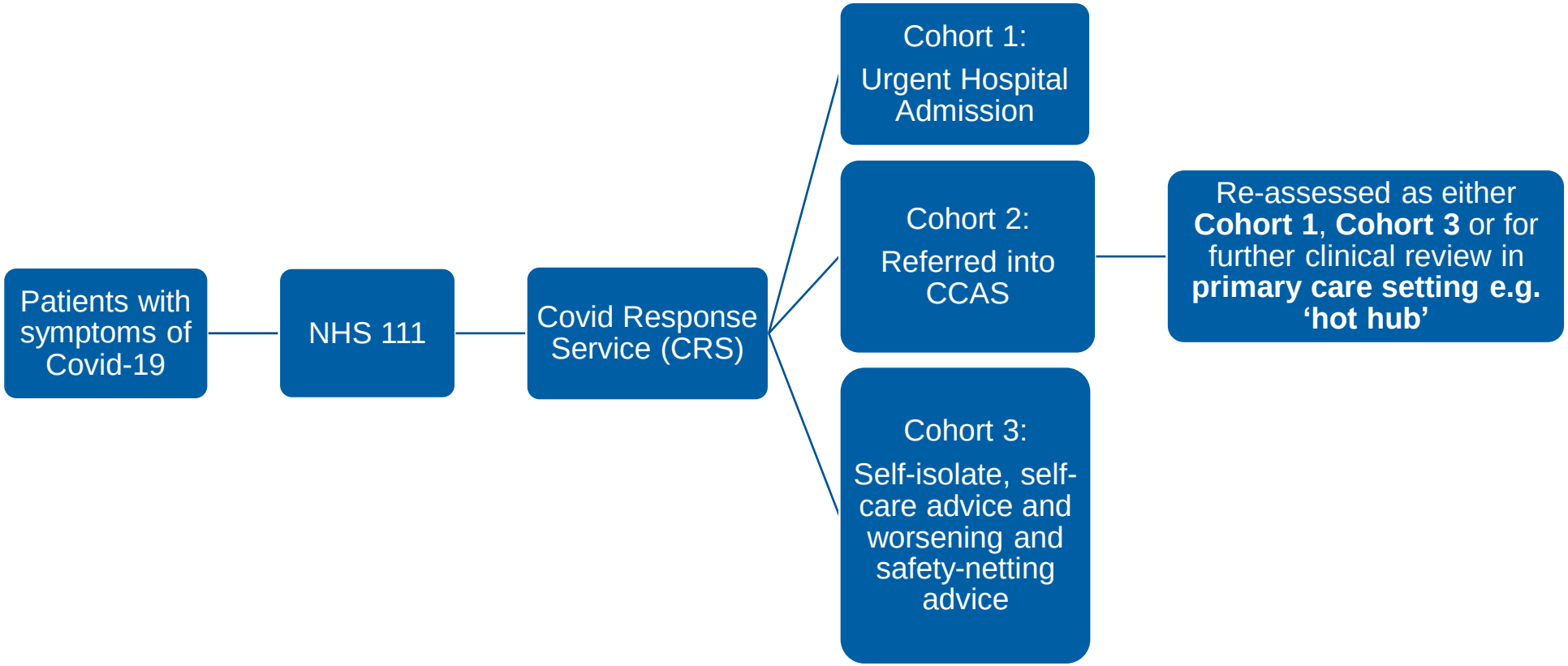
The Patient Journey



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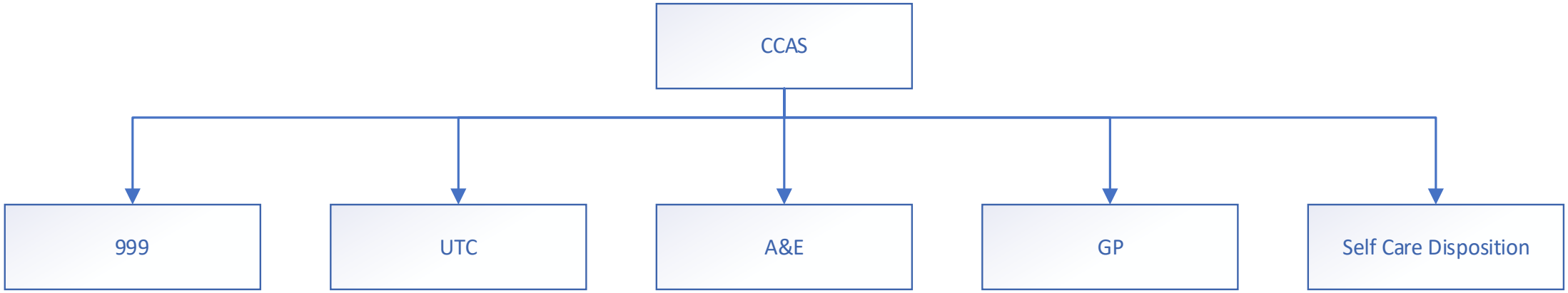
Patient Journey – Route out



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Clinical Governance

- **30** GP auditors, supported by a wider Clinical Governance Team wrapping around the whole process which provided consistency and support
- **2** Joint Clinical Governance Medical Leads, under the guidance of a Clinical Assurance Director
- **1.6 million** calls offered by the **Covid Response Services**
- **547 064** calls were handled by CCAS-1 and **5738** of these consultations were audited
- **1%** of CCAS GP consultations sampled for clinical assurance

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Royal College of General Practitioners

Royal College of Paediatrics and Child Health

Leading the way in Children's Health

The College of Emergency Medicine

Urgent and Emergency Care Clinical Audit Toolkit

CLINICIAN NAME :	Skill Set:			Type of Audit
Enter name here				
Universal Criteria				COMMENTS
Elicits REASON for call				
A. Introduces themselves by name and organisation				
B. Patient/tator (or re-tator) their name and two other demographic details.				
C. Confirms current location				
D. Seeks permission to speak to third party where necessary				
E. Gives a good explanation of the process				
F. Clearly Identifies presenting symptoms				
Identifies EMERGENCY or SERIOUS situations				
A. Asks appropriate questions to identify or exclude [or suggest] such situations				
B. Appropriate use of ILTC protocols				
C. Phrases questions in a way the caller can understand				
D. Quickly establishes the need to respond as a serious or emergency situation and acts				
Takes an appropriate HISTORY (or uses algorithm appropriately)				
A. Explores symptoms and symptom progression (considering COVID, current illness and co-morbidities)				
B. Elicits social history (including household members, social contacts, work and smoking)				
C. Uses GP connect with permission to access Summary Care Record.				
D. Identifies relevant PMH/DH [including drug allergy]				
E. Identifies Covid risk factors e.g. exposure risk, obesity, ethnicity and LTCs.				
Carries out appropriate ASSESSMENT				
A. Targeted information gathering (or use of decision support if available) to aid decision making				
B. Links findings to history				
Draws CONCLUSIONS that are supported by the history				
A. Constructs appropriate diagnosis or differential based on the history / identifies appropriate 'symptom cluster'				
B. Streams / Refers patient appropriately				
Appropriate MANAGEMENT and ADVICE following assessment				
A. Decisions conform to clinical guidelines (with exceptions clearly justified)				
B. Gives appropriate advice on escalation e.g. asthma, DMARDS, steroids pregnancy and diabetes				
C. Gives appropriate testing & isolation advice, including for negative tests (for patient and household)				
D. Decisions are safe for the patient and the wider public				
Correctly fills in appropriate DOCUMENTATION				
A. Documents information clearly including patient advice				
B. Written record matches audio record				
Appropriate PRESCRIBING behaviour				
A. Generics used [unless inappropriate]				
B. Formulary based [where available]				
C. Follows evidence base or recognised good practice				
D. Appropriate use of e-prescribing				
Displays adequate SAFETY-NETTING				
A. Clearly gives advice about when and who to call back				
B. Records advice given (warning instruction)				
Additional Criteria if Applicable				
Did the clinician address any potential SAFEGUARDING issues?				
A. Do the notes demonstrate an awareness of safeguarding issues (where relevant)?				
B. If safeguarding issues were suspected was the patient referred to the appropriate service?				
C. If an injured child or vulnerable adult; did the clinician explore the possibility of intentional injury?				
Makes appropriate use of IT/Protocols/Algorithms				
A. Adequate data recording				
[illegible]				
C. Use of IT tools and telephony where available (Care advice, DoS, Appointments and Prescribing)				
D. Use of SMS messaging with appropriate URLs				
E. Keeps patient on the line until DOS completed for referrals				
F. Appropriate referral to another service if required (service and time frame)				
Displays EMPOWERING behaviour				
A. Identifies patients concerns (health beliefs)				
B. Involves patient in decision-making				
C. Uses self-help advice [inc. signpost to appropriate website]				
D. Responds appropriately to caller requests for information				
Develops RAPPORT				
A. Demonstrates good listening skills				
B. Communicates effectively [including use of English]				
C. Conducts themselves in a professional manner				
			Case Summary:	
			Auditor's Comments:	
			Adastra Number:	
			Auditor:	
			Audited call number (1, 2 3)	

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Audit

Prospective audit

- Random or Focused

Reactive audit

- Complaints
- Incidents from Internal & External sources
- Health Care Professional feedback (HCP)
- Safeguarding concerns

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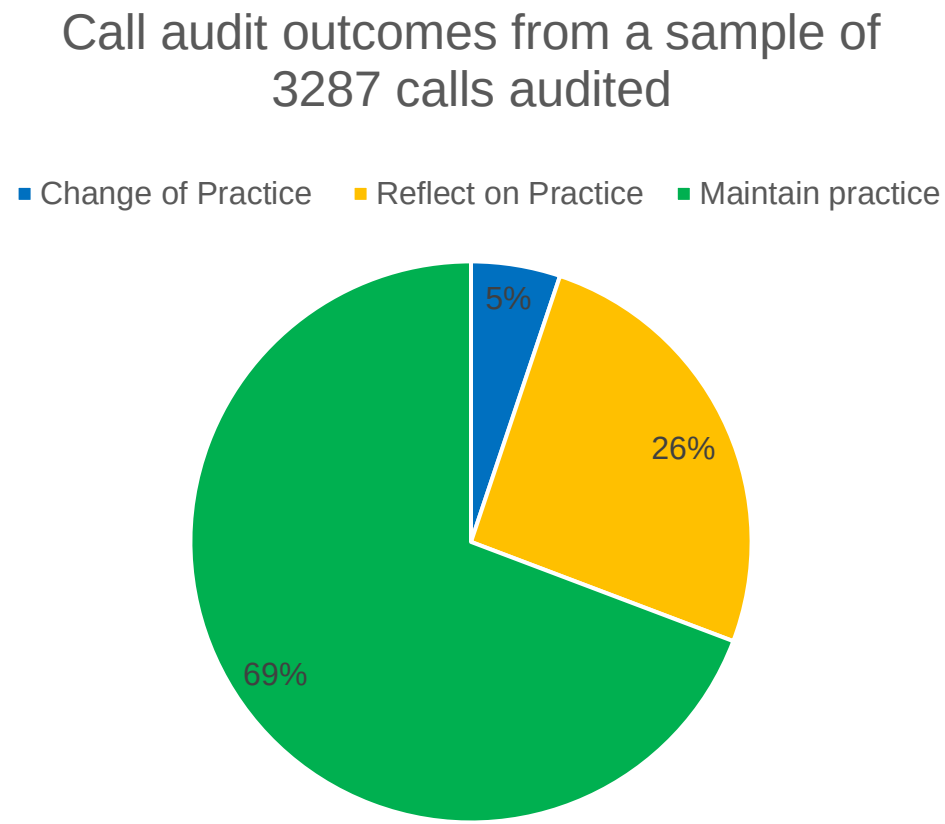
Learning from Audit

- From 5738 calls audited, 3% were graded as a change of practice outcome
- There were often multiple issues within a call that would lead the auditor to have a higher index of concern
- 41 out of 46 indicators on the audit tool contributed *at least once* to the formulation of a Change Practice outcome; this lends support to the use of a detailed audit tool



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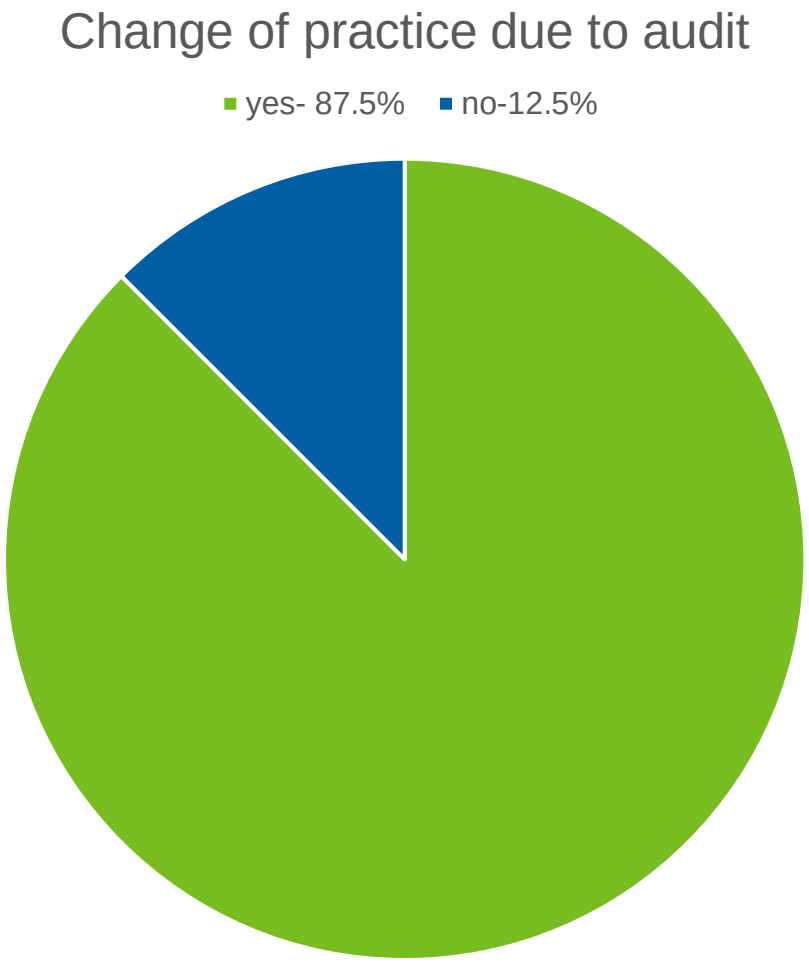
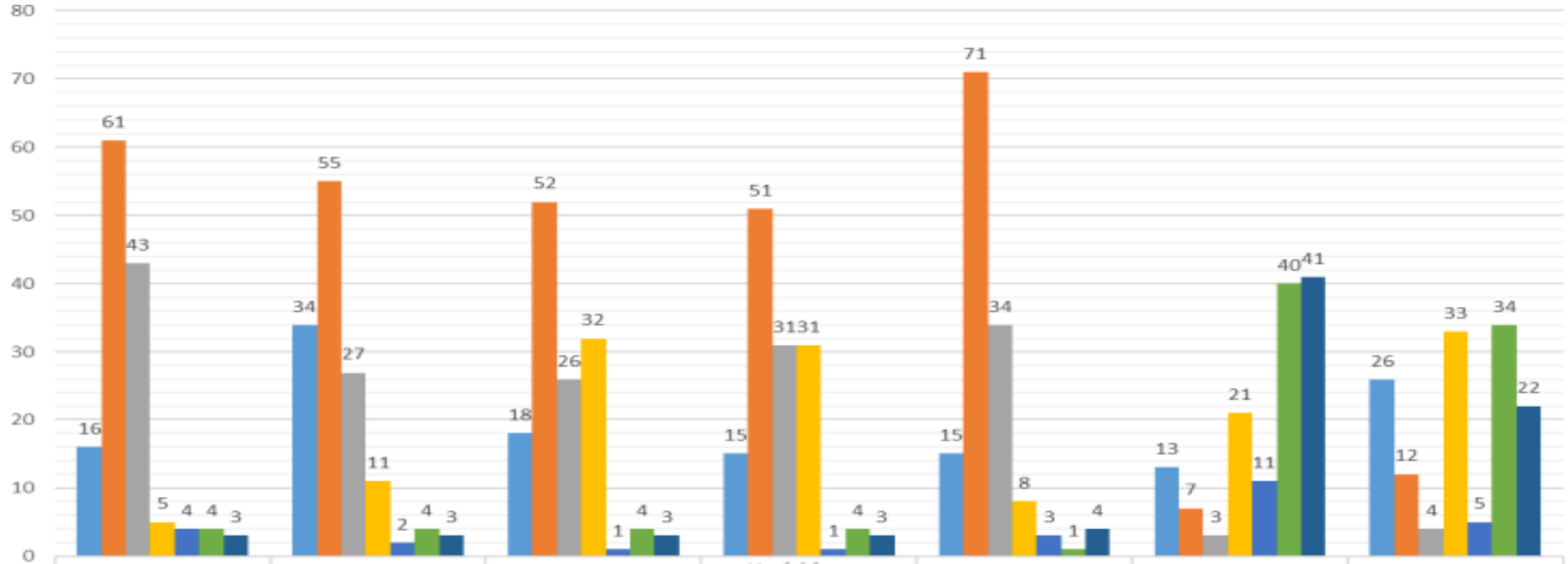
Impact- Changed practice



87.5% of GPs reported changing their practice in response to their audit feedback

The audit process felt...



	Supportive	Educational	Useful for my CPD	Useful for my appraisal	Reassuring	Undermining	Daunting
Slightly Agree	16	34	18	15	15	13	26
Agree	61	55	52	51	71	7	12
Strongly Agree	43	27	26	31	34	3	4
Neither Agree or Disagree	5	11	32	31	8	21	33
Slightly disagree	4	2	1	1	3	11	5
Disagree	4	4	4	4	1	40	34
Strongly Disagree	3	3	3	3	4	41	22

Slightly Agree Agree Strongly Agree Neither Agree or Disagree Slightly disagree Disagree Strongly Disagree

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The metrics that do matter

- **Clinician**
  - Focused and holistic feedback on a specific patient encounter using a coaching approach
- **Patient**
  - Homogenization of clinical practice and assuring best evidence base
- **Organisation**
  - Sharing best practice
  - Clinical assurance for commissioners
  - Promoting patient safety
  - Supporting a digital transformation agenda with patient safety at the core
  - Identifying challenges or areas of risk early

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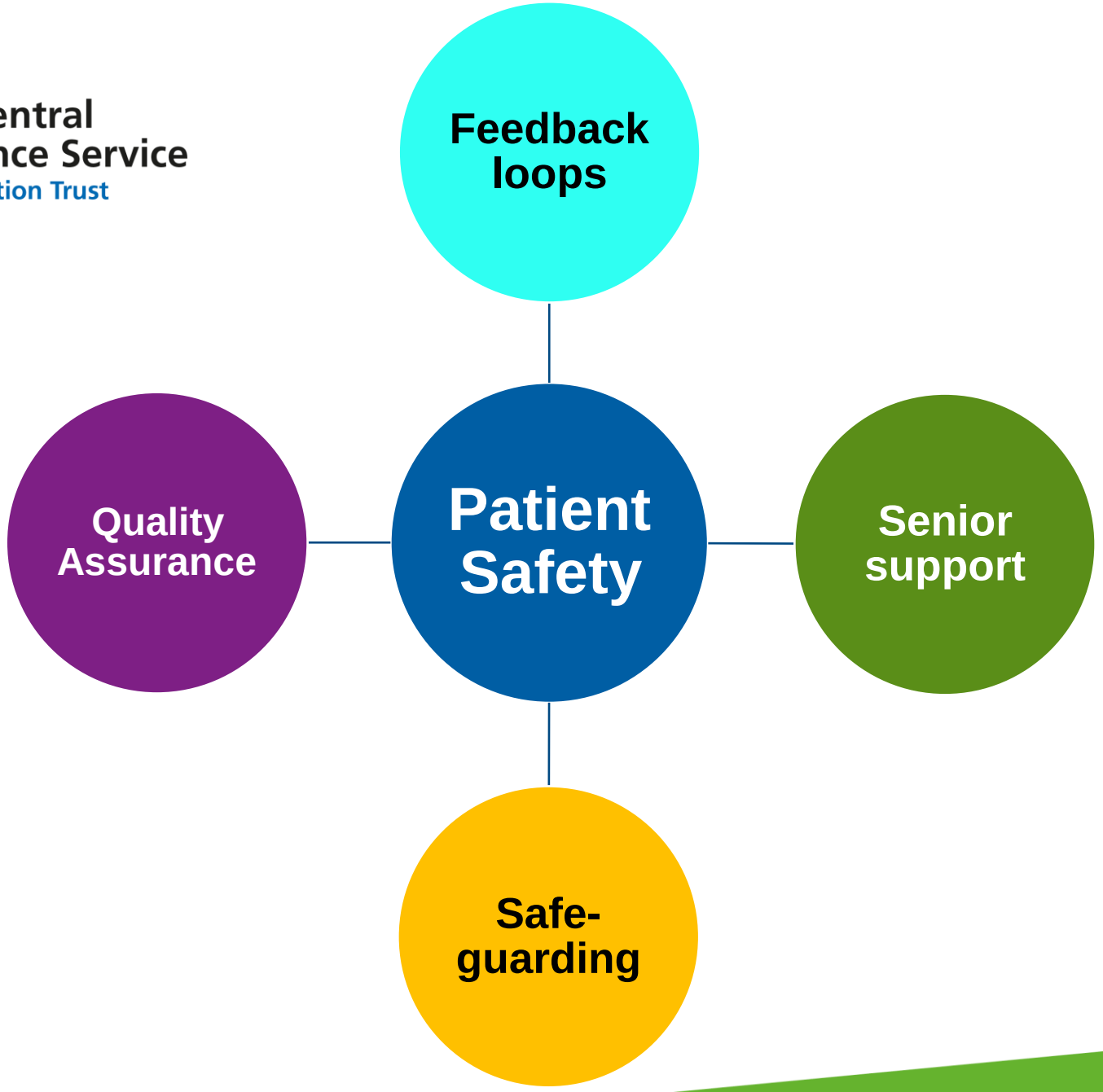

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….audited by the clinicians (GPs) who were taking the calls themselves so understood the pressures and guided us to ***improve the patient safety / care*** *and our own clinical practice*

In a work environment where without audit no-one might ever listen to your calls or check your records I found it useful to have this ***oversight*** *to ensure that CCAS was happy with my work. all assessors were* ***generally supportive****. without audit it would have felt not safe/disjointed and very independent/lonely in my opinion*

As Covid-19 was an entirely new disease, with evolving knowledge and changes to clinical management , the audit process ***reassured me that I remained clinically safe*** *in the remote assessment of patients who were at times very ill*

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*I loved the detail. **The best feed back I have ever had**….overall a very positive experience*

*Confirmation that my **management is safe** and I should continue working in the same way, appreciation and endorsement*

Extremely pleasant, thorough; pedantic at times, but sometimes with good reason

*Being able to be helped to do things better in a **formative and supportive** way. Auditors sharing good practice*

*I had **never had** my consultations peer reviewed in over 20 years of GP - very useful feedback mostly…*

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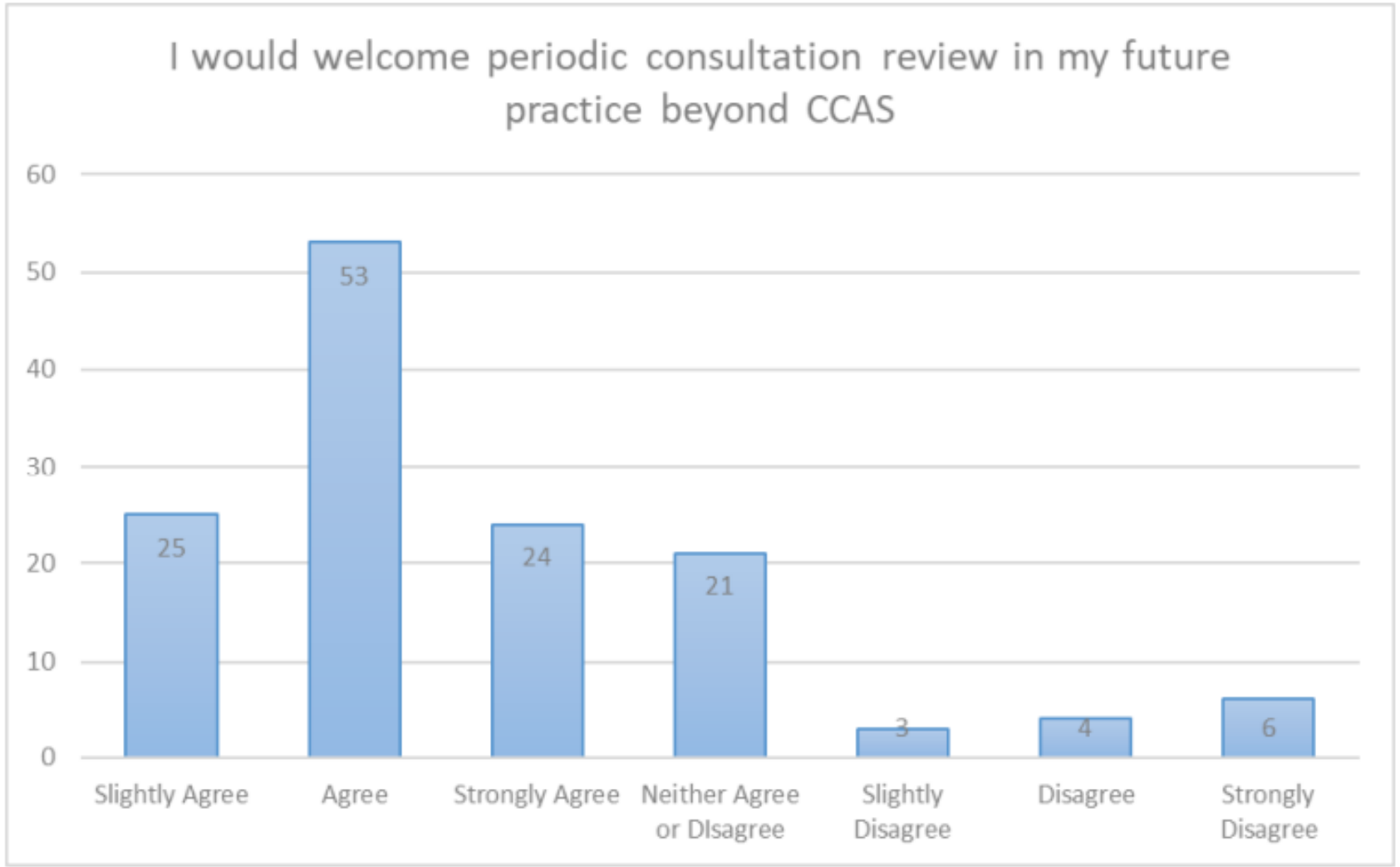
What's next?

Responses	
Slightly Agree	25
Agree	53
Strongly Agree	24
Neither Agree or Disagree	21
Slightly Disagree	3
Disagree	4
Strongly Disagree	6
Grand Total	136



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Conclusion

Valuable to SCAS and our patients especially in the context of the pandemic response

Good for Continuous Professional Learning

Promotes an open, honest and transparent approach to performance and quality review

Wider conversation with other providers - sharing consensus on best practice

Disseminating our learning

- Quality assurance of remote clinical assessments in the NHS - The Lancet
- Safety netting in the COVID-19 Clinical Assessment Service | British Journal of General Practice (bjgp.org)

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Thank you

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Acknowledgements

The COVID-19 Clinical Assessment Service (CCAS) was commissioned by **NHS E/I** and created by the **NHS South, Central and West Commissioning Support Unit** as part of the **National Pandemic Flu Service** and was hosted and managed by the **South Central Ambulance Service NHS Foundation Trust (SCAS).**

The CCAS would not have been possible without the outstanding leadership, innovation, unrelenting dedication and collaboration across stakeholders and their Operations, Human resources and Clinical teams.

We would like to specifically thank our colleagues for their assistance and support with this presentation:

Enid Povey, Carol Rogers, Ruth Allanson, Prof Helen Young, Laura Calow, Caron Brittan, Victoria Dooley and Dr Will Brooks.

With additional thanks to;

Lynne Heald, Kathy Agrebi, Sue Tucker, Janet Crowe and the many others in the Delivery teams

Dr Jean Challiner, Dr Caroline Warren, Lesley Selfe, 30 GP Auditors and our Clinical Governance team

Liam Williams and the NHS SCW CSU team

The NHS Patient Safety Conference 2022:
Breaking a culture of defensiveness

SPEAKING NOW

Dr Jorge Zimbron

Consultant Psychiatrist at Springbank Ward, Cambridge and Peterborough NHS Foundation Trust

I will be discussing…

"Patient Safety Best Practice Session: The Springbank Ward"

NHS
Cambridgeshire and Peterborough
NHS Foundation Trust

Springbank Ward

Managing extreme risk at Springbank Ward, Specialist Personality Disorder Unit.

Dr Jorge Zimbron
Consultant in General Adult Psychiatry
Jorge.Zimbron@cpft.nhs.uk

8th June, 2022

Pride in our adults and specialist mental health services

SPRINGBANK WARD

Opened May 2011

Specialist Personality Disorder unit

Unique in the NHS

- Private
- Forensic

Inclusion

- Women, trans, and non-binary
- Severe Borderline Personality Disorder
- Co-morbidity is the norm
- Failure to manage in the community / acute wards

Treatment

- 12 beds
- 1 year programme
- DBT, pharmacotherapy, occupational therapy, music therapy, physiotherapy, and others

OUTLINE

Personality Disorder

The Springbank Experience

- Risk Management

Parallels

DIAGNOSIS

PD is about behaviour.

3 Ps:

- Problematic
- Pervasive
- Persistent

Biopsychosocial causes

Multiple patterns

- Chronically suicidal
  - Multiple suicide attempts
  - Self-harm

ICD – 10	DSM IV & V	DSM V Hybrid model
Paranoid	Paranoid	
Schizoid	Schizoid	
(schizotypal under F20-29)	**Schizotypal**	Schizotypal
Dissocial	**Antisocial**	Antisocial
Emotionally Unstable (Impulsive and borderline types)	**Borderline**	Borderline
Histrionic	Histrionic	
Anankastic	**Obsessive-compulsive**	Obsessive-compulsive
Anxious (avoidant)	Avoidant	Avoidant
Dependent	Dependent	
Other (eccentric, immature, narcissistic, passive aggressive, "haltlose", psychoneurotic)	**Narcissistic**	Narcissistic
Unspecified		
Mixed		
Enduring personality change (catastrophe or psychiatric illness)		

LIFE EXPECTANCY

J Psychosom Res. 2012 Aug;73(2):104-7. doi: 10.1016/j.jpsychores.2012.05.001. Epub 2012 May 26.

Life expectancy at birth and all-cause mortality among people with personality disorder

Marcella Lei-Yee Fok [1], Richard D Hayes, Chin-Kuo Chang, Robert Stewart, Felicity J Callard, Paul Moran

Affiliations + expand

PMID: 22789412 DOI: 10.1016/j.jpsychores.2012.05.001

Abstract

Objective: It is well established that serious mental illness is associated with raised mortality, yet few studies have looked at the life expectancy of people with personality disorder (PD). This study aims to examine the life expectancy and relative mortality in people with PD within secondary mental health care.

Methods: We set out to examine this using a large psychiatric case register in southeast London, UK. Mortality was obtained through national mortality tracing procedures. In a cohort of patients with a primary diagnosis of PD (n=1836), standardised mortality ratios (SMRs) and life expectancies at birth were calculated, using general population mortality statistics as the comparator.

Results: Life expectancy at birth was 63.3 years for women and 59.1 years for men with PD-18.7 years and 17.7 years shorter than females and males respectively in the general population in England and Wales. The SMR was 4.2 (95% CI: 3.03-5.64) overall; 5.0 (95% CI: 3.15-7.45) for females and 3.5 (95% CI: 2.17-5.47) for males. The highest SMRs were found in the younger age groups for both genders.

Conclusion: People with PD using mental health services have a substantially reduced life expectancy, highlighting the significant public health burden of the disorder.

177	Angola	**62.22**	65.12	59.46
178	Zimbabwe	**62.16**	63.66	60.39
179	Togo	**62.13**	63.08	61.16
179	Mozambique	**62.13**	64.95	59.05
180	DR Congo	**61.60**	63.21	60.01
181	Eswatini	**61.05**	65.67	56.98
182	Mali	**60.54**	61.39	59.69
183	Cameroon	**60.32**	61.66	58.99
184	Equatorial Guinea	**59.82**	61.08	58.76
185	Guinea-Bissau	**59.38**	61.33	57.31
186	Côte d'Ivoire	**58.75**	60.13	57.50
187	South Sudan	**58.74**	60.31	57.21
188	Somalia	**58.34**	60.11	56.62
189	Sierra Leone	**55.92**	56.78	55.01
190	Nigeria	**55.75**	56.75	54.80
191	Lesotho	**55.65**	58.90	52.52
192	Chad	**55.17**	56.65	53.73
193	Central African	**54.36**	56.58	52.16

MORTALITY IN WOMEN

Cause of death	Standardised mortality ratios (95% CI)				
	All	Cluster A	Cluster B	Cluster C	Other
Total	6.1 (5.8–6.4)	4.3 (3.5–5.3)	6.4 (5.9–7.0)	5.0 (4.0–6.4)	6.3 (5.9–6.8)
Natural	3.6 (3.4–3.9)	3.4 (2.7–4.4)	3.4 (3.0–3.8)	3.7 (2.7–5.0)	3.8 (3.5–4.2)
Infections	8.6 (5.6–13.2)	5.3 (0.8–37.8)	2.2 (0.5–8.7)	8.2 (1.2–58.3)	14.1 (8.7–22.6)
Cancer	1.6 (1.4–1.9)	2.4 (1.6–3.5)	1.9 (1.5–2.3)	1.4 (0.7–2.6)	1.3 (1.1–1.7)
Endocrine	6.8 (4.8–9.6)	2.6 (0.4–18.1)	3.9 (1.8–8.1)	12.0 (3.9–37.1)	9.1 (6.0–13.9)
Mental					
Substance misuse	11.4 (7.2–18.2)	–	15.1 (7.8–28.9)	13.3 (1.9–94.7)	10.2 (5.1–20.4)
Other	13.3 (9.2–19.3)	14.1 (3.5–56.3)	9.7 (4.9–19.4)	32.3 (10.4–100)	14.4 (8.7–23.9)
Nervous system	4.9 (3.5–6.7)	1.7 (0.2–12.1)	4.2 (2.4–7.3)	2.6 (0.4–18.7)	6.1 (4.1–9.2)
Cardiovascular	5.9 (5.2–6.6)	5.0 (3.2–7.8)	5.0 (3.9–6.2)	7.5 (4.8–11.7)	6.5 (5.5–7.7)
Respiratory	7.9 (6.3–9.9)	9.3 (4.7–18.7)	8.6 (5.9–12.4)	5.5 (1.8–17.1)	7.4 (5.3–10.4)
Gastrointestinal	4.9 (3.6–6.6)	3.9 (1.3–12.2)	3.1 (1.7–5.8)	4.2 (1.0–16.6)	6.4 (4.4–9.3)
Other	6.1 (4.8–7.7)	2.5 (0.6–10.1)	6.3 (4.3–9.2)	1.9 (0.3–13.8)	6.8 (4.9–9.4)
Unnatural	22.0 (20.4–23.6)	12.8 (8.5–19.3)	23.2 (20.8–25.9)	18.0 (11.8–27.3)	22.2 (20.1–24.7)
Suicide	32.8 (30.0–35.8)	21.5 (13.4–34.7)	34.5 (30.2–39.3)	25.8 (15.3–43.5)	33.0 (29.1–37.3)
Undetermined intent	22.3 (18.5–26.9)	7.2 (1.8–28.7)	26.4 (20.2–34.6)	16.0 (5.2–49.7)	21.2 (16.1–27.8)
Homicide	5.6 (2.8–11.3)	–	3.2 (0.8–12.8)		8.7 (3.9–19.4)
Traffic accidents	2.8 (1.7–4.6)	–	3.0 (1.4–6.3)	5.5 (0.8–38.8)	2.7 (1.3–5.6)
Other	15.2 (12.4–18.6)	9.9 (3.7–26.3)	15.1 (10.9–20.8)	15.0 (5.6–39.9)	16.1 (12.2–21.3)

ISSUE: FEAR

Staff

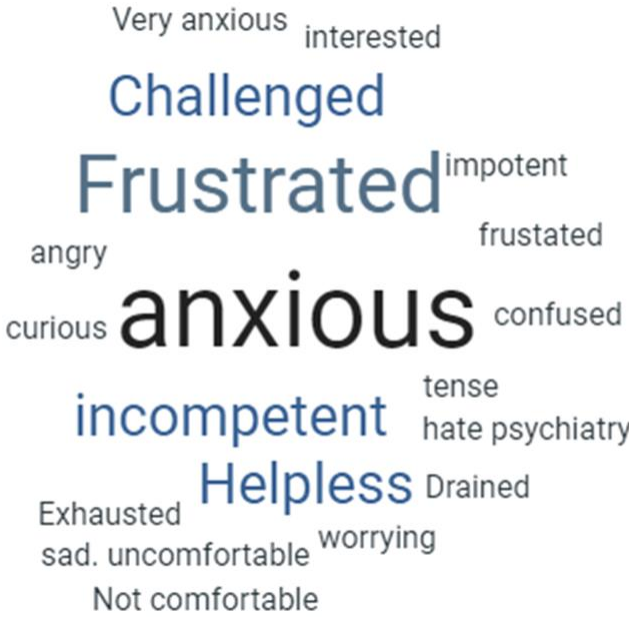
- Complexity
  - Ignorance
- Death
  - Legal system
  - Media
- Security
  - Career
  - Reputation
- Burn-out

Patient

- Death
- Disability
- Life-sentence
- Loss of support

HOW DO PEOPLE WITH A PERSONALITY DISORDER MAKE YOU FEEL?

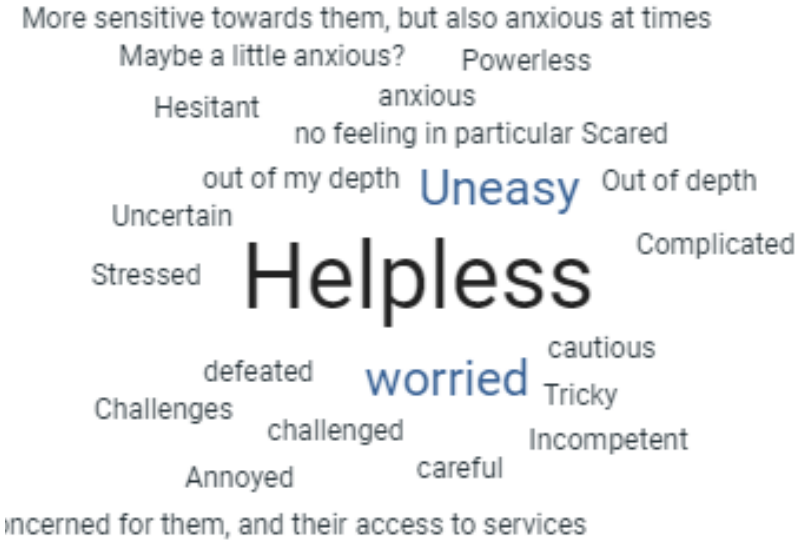
18 psychiatrists
(consultants and trainees)
November 2020



61 pharmacists.

10th Annual International
Psychiatric Pharmacy
Conference.

29 GPs and staff in primary care
15.03.2021



THE SPRINGBANK EXPERIENCE

RISK MANAGEMENT

2 treatment models:

- Old (May 2011 – April 2015)
  - Risk Containment
- New (May 2015 – Present)
  - Autonomy

RISK CONTAINMENT MODEL (2011 -2015)

Therapies

- Medication
- **Dialectical Behaviour Therapy**
- Occupational Therapy
- Seclusion
- Exercise
- Physiotherapy

Containment Autonomy

Delivery

- **Excellent NHS staff**
- MHA
- Locked ward
- Restricted items
- Personal searches
- Restricted leave
- Punishment / Reward approach
- Observation levels
- Physical restraint & rapid tranquilisation
  - 'Adverse adulthood experiences!'

Standard approach

RISK CONTAINMENT

Goal: *keep person alive*

For acute modifiable risks

In-patient treatment

MHA

Containment Autonomy

Assumptions

- Hospitals are safer
- Patients/SUs lack capacity

Pros:

- "Feels safe"
- Short-term benefit

Cons:

- "Feels wrong"
- Promotes dependence

LAINGBUISSON REPORT

13.5% of the NHS MH budget goes to the independent sector.

10,123 private beds

- NHS 17,610

15-20% profit margins

Lack of competition

- 4 providers get 2/3 of the money
- 71 facilities inadequate

NHS

NHS paying £2bn a year to private hospitals for mental health patients

Exclusive: Fears grow that bed shortages have left NHS increasingly reliant on independent sector

'I thought she'd be safe': a life lost to suicide in a place meant for recovery

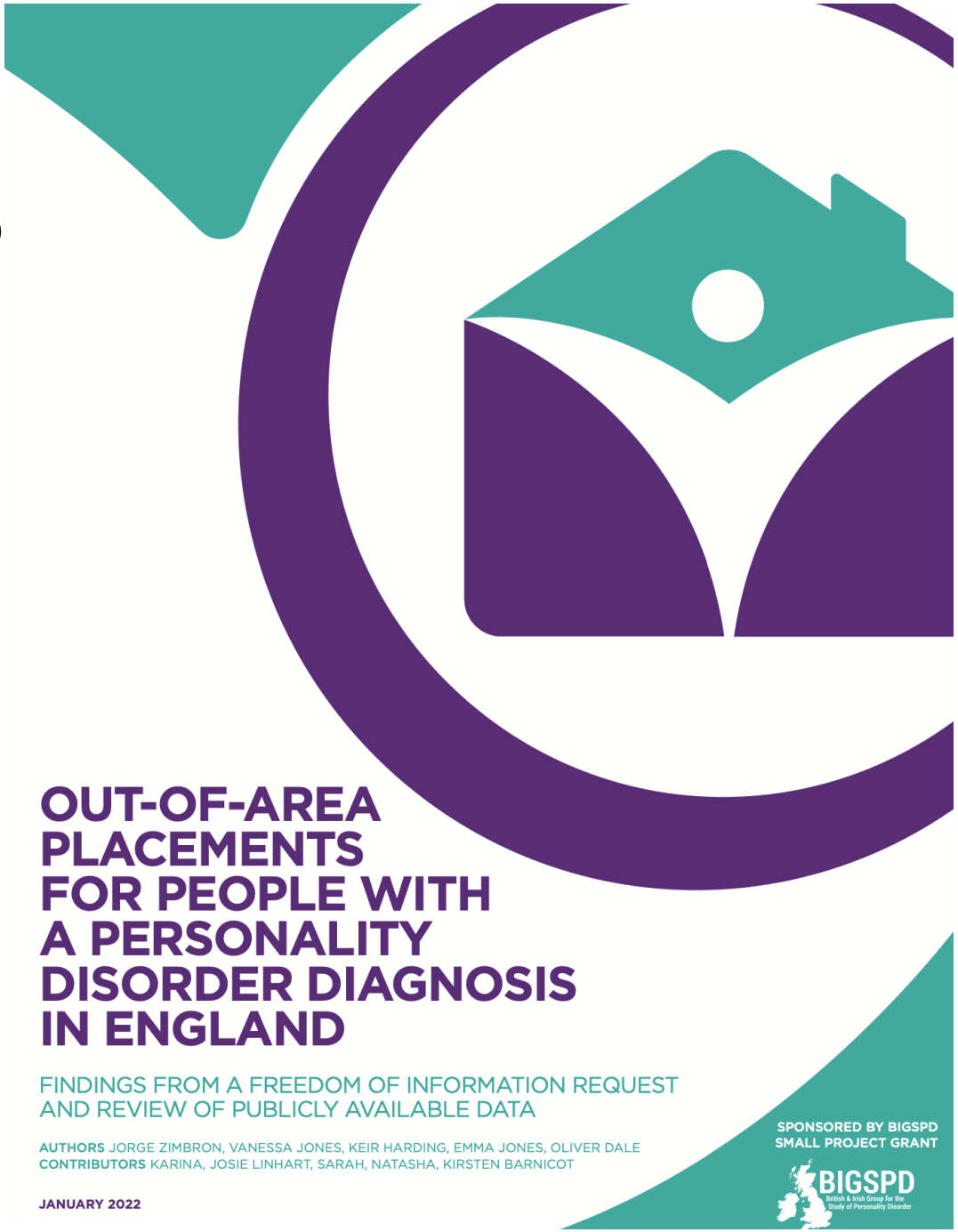
Denis Campbell *and* Anna Bawden

Sun 24 Apr 2022 15.00 BST

OUT OF AREA ADMISSIONS

2022

22 – 46% PD (~70% MHA)



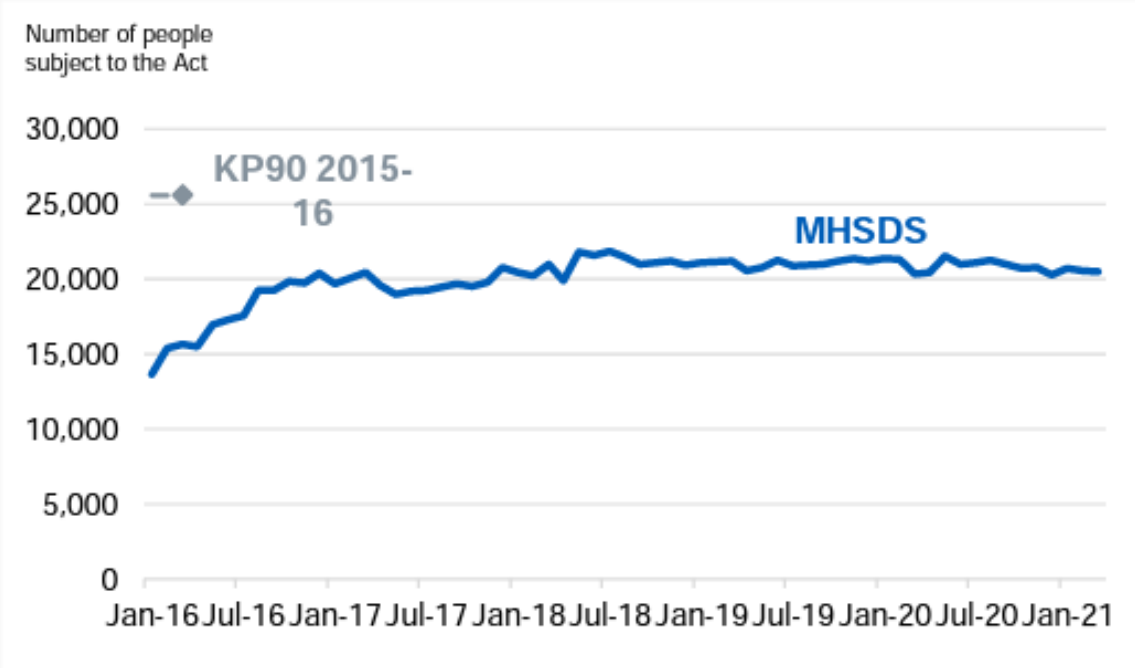
Publication, Part of Mental Health Act Statistics, Annual Figures

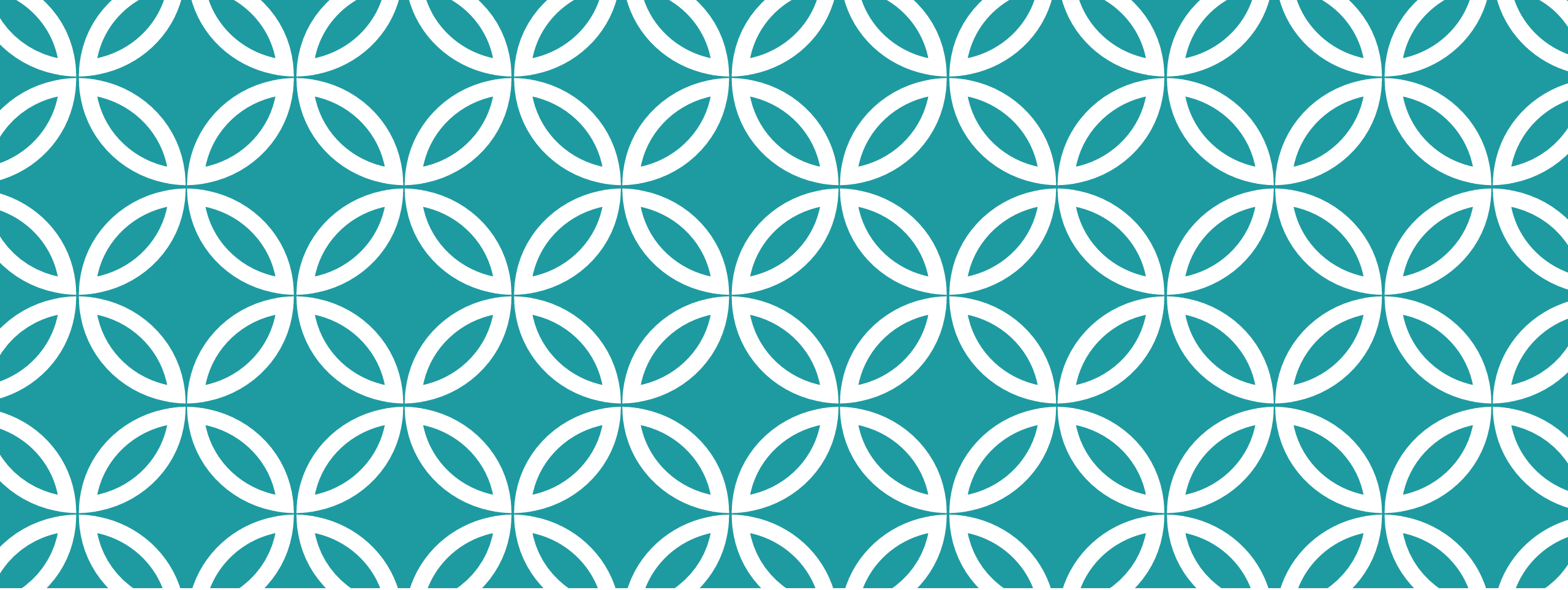
Mental Health Act Statistics, Annual Figures - 2020-21

Official statistics, National statistics

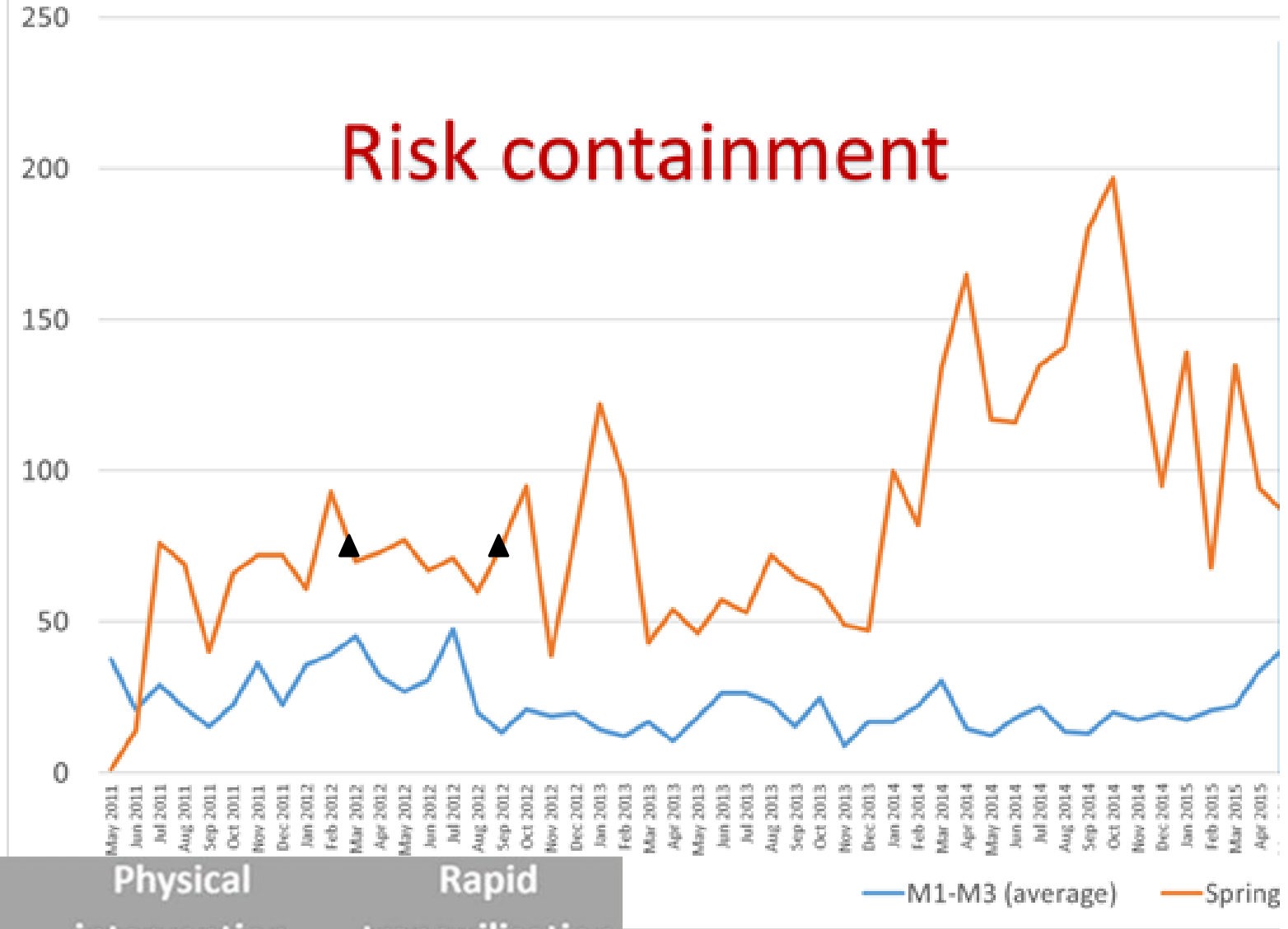
Publication Date:	26 Oct 2021
Geographic Coverage:	England
Geographical	Mental Health Trusts, NHS Trusts, Independent Sector Health Care
Granularity:	Transformation Partnerships
Date Range:	01 Apr 2014 to 31 Mar 2021

The number of people reported in the MHSDS as subject to the Act at each month-end[8] has increased from 13,628 on 31st January 2016 to 20,494 on 31st March 2021. This compares to 25,577 people recorded in the last annual publication sourced from the KP90 (on 31st March 2016).





OUTCOMES



Year	Physical intervention	Rapid tranquilisation
2012	52	36
2013	57	45
2014	59	44
2015	64	18

EXPERIENCE

Incidents

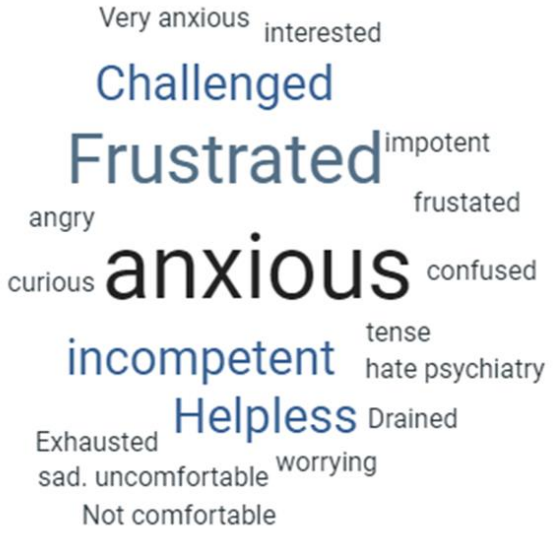
- Daily alarms
- Regular physical interventions
- Frequent injuries

Staff vacancies

- High turn-around
- 7 consultants in 4 years

Ward Reputation

- Difficult place to work
- Difficult group of patients
- Students not allowed



AMBITION

Reduce incidents

Improve safety

Improve patient and staff experience

PREVALENCE

Volume 213, Issue 6 December 2018 , pp. 709-715

Cited b

Acc

Prevalence of personality disorders in the general adult population in Western countries: systematic review and meta-analysis

Jana Volkert [a1], Thorsten-Christian Gablonski [a2] and Sven Rabung [a3]

DOI: https://doi.org/10.1192/bjp.2018.202 Published online by Cambridge University Press: 28 September 2018

Abstract

Background

Personality disorder is a severe health issue. However, the epidemiology of personality disorders is insufficiently described and surveys report very heterogeneous rates.

Aims

We aimed to conduct a meta-analysis on the prevalence of personality disorders in adult populations and examine potential moderators that affect heterogeneity.

Method

We searched PsycINFO, PSYNDEX and Medline for studies that used standardised diagnostics (DSM-IV/-5, ICD-10) to report prevalence rates of personality disorders in community populations in Western countries. Prevalence rates were extracted and aggregated by random-effects models. Meta-regression and sensitivity analyses were performed and publication bias was assessed.

Results

The final sample comprised ten studies, with a total of 113 998 individuals. Prevalence rates were fairly high for any personality disorder (12.16%; 95% CI, 8.01–17.02%) and similarly high for DSM Clusters A, B and C, between 5.53 (95% CI, 3.20–8.43%) and 7.23% (95% CI, 2.37–14.42%). Prevalence was highest for obsessive–compulsive personality disorder (4.32%; 95% CI, 2.16–7.16%) and lowest for dependent personality disorder (0.78%; 95% CI, 0.37–1.32%). A low prevalence was significantly associated with expert-rated assessment (versus self-rated) and reporting of descriptive statistics for antisocial personality disorder.

Conclusions

Epidemiological studies on personality disorders in community samples are rare, whereas prevalence rates are fairly high and vary substantially depending on samples and methods. Future studies investigating the epidemiology of personality disorders based on the DSM-5 and ICD-11 and models of personality functioning and traits are needed, and efficient treatment should be a priority for healthcare systems to reduce disease burden.

Declaration of interest

None.

MYTH: RISK PREDICTION

We cannot predict risk at an individual level

For every completed suicide there are 200 attempts.

March 13, 2019

Prediction Models for Suicide Attempts and Deaths

A Systematic Review and Simulation

Bradley E. Belsher, PhD[1,2]; Derek J. Smolenski, PhD, MPH[1]; Larry D. Pruitt, PhD[1]; et al

» Author Affiliations

JAMA Psychiatry. 2019;76(6):642-651. doi:10.1001/jamapsychiatry.2019.0174

Key Points

Question Have advances in statistical modeling improved the predictive validity of suicide prediction algorithms sufficiently to render their predictions actionable?

Findings In this systematic review of 17 studies including 64 unique suicide prediction models, the models had good overall classification and low positive predictive values. Use of these models would result in high false-positive rates and considerable false-negative rates if implemented in isolation.

Meaning At present, the performance of suicide prediction models suggests that they offer limited practical utility in predicting suicide mortality.

NEW SPRINGBANK MODEL (2015 – 2021)

Therapies

- Medication
- **Dialectical Behaviour Therapy**
- Occupational Therapy
- Sensory integration
- Exercise
- Physiotherapy

Delivery

- **Excellent NHS Staff**
- Least-restrictive approach
  - MHA avoided
- **Capacity is assumed**
  - Even in crises
- Recovery focus
- Patient centred care
- **Positive-risk-taking**
- **Shared-decision making**
- **Shared values**
- Co-production
- Distributed leadership
- Therapeutic community

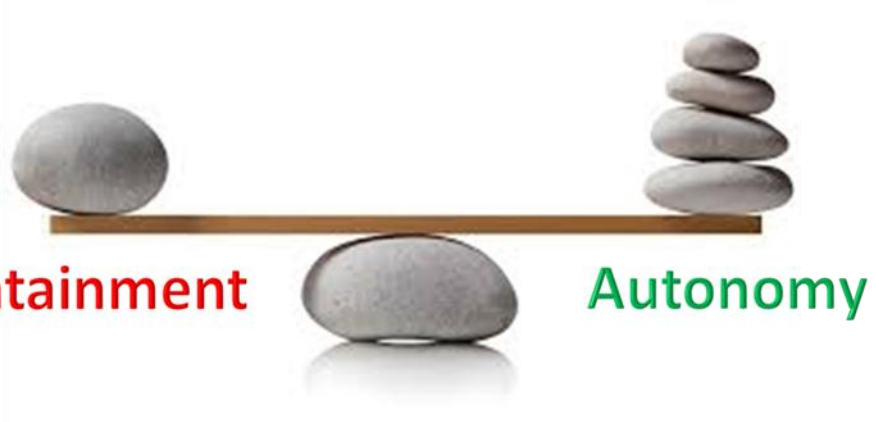
POSITIVE RISK TAKING

Goal: ***Enable people to manage and enjoy life***

Looks at long-term risks and opportunities

Requirements:

- Clear formulation
- Detailed history
- Good relationships
- Communication with relatives
- Organisational support



POSITIVE RISK TAKING

Assumes no risk-free option

Assumes capacity

Assumes chronic risk

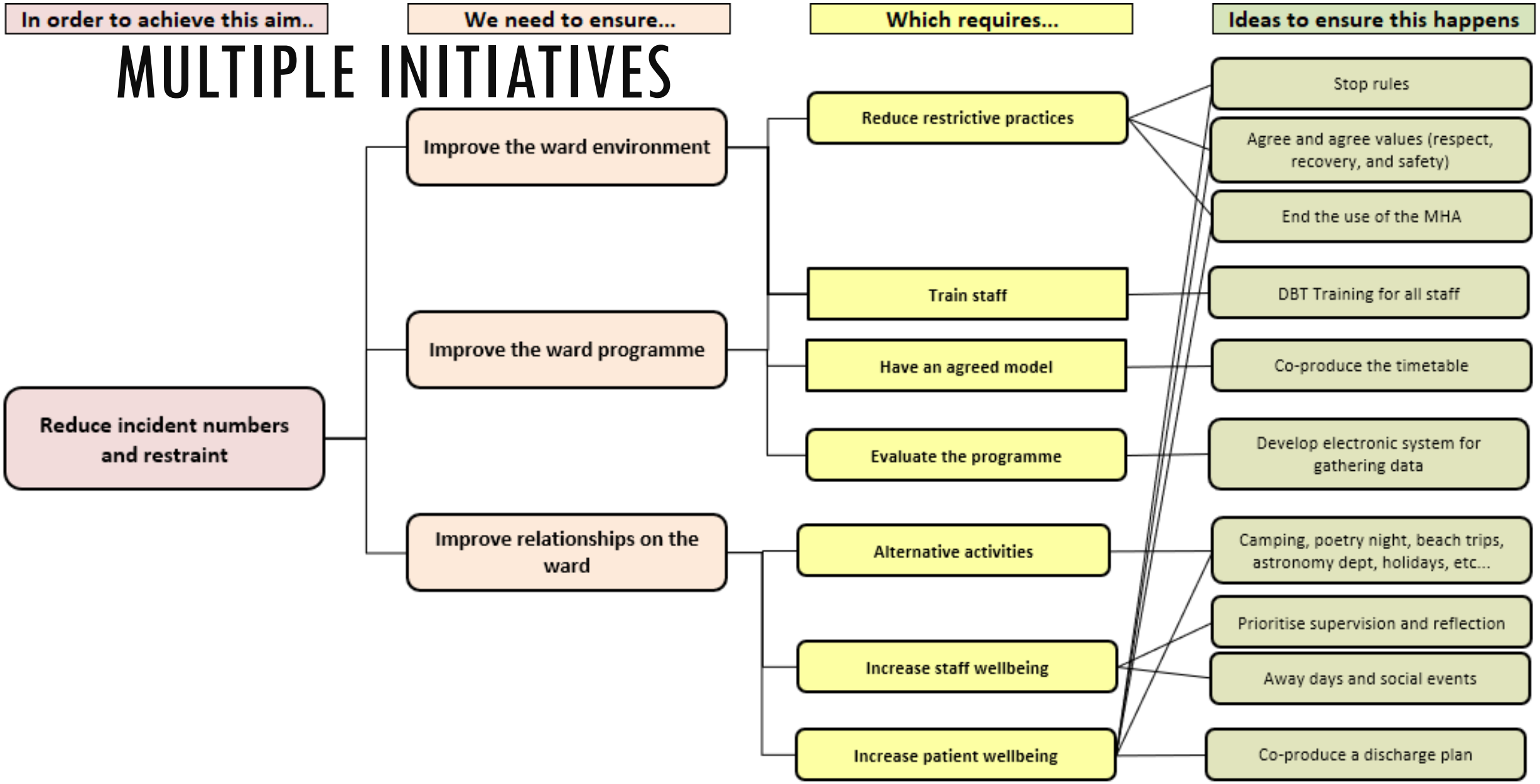
Pros:

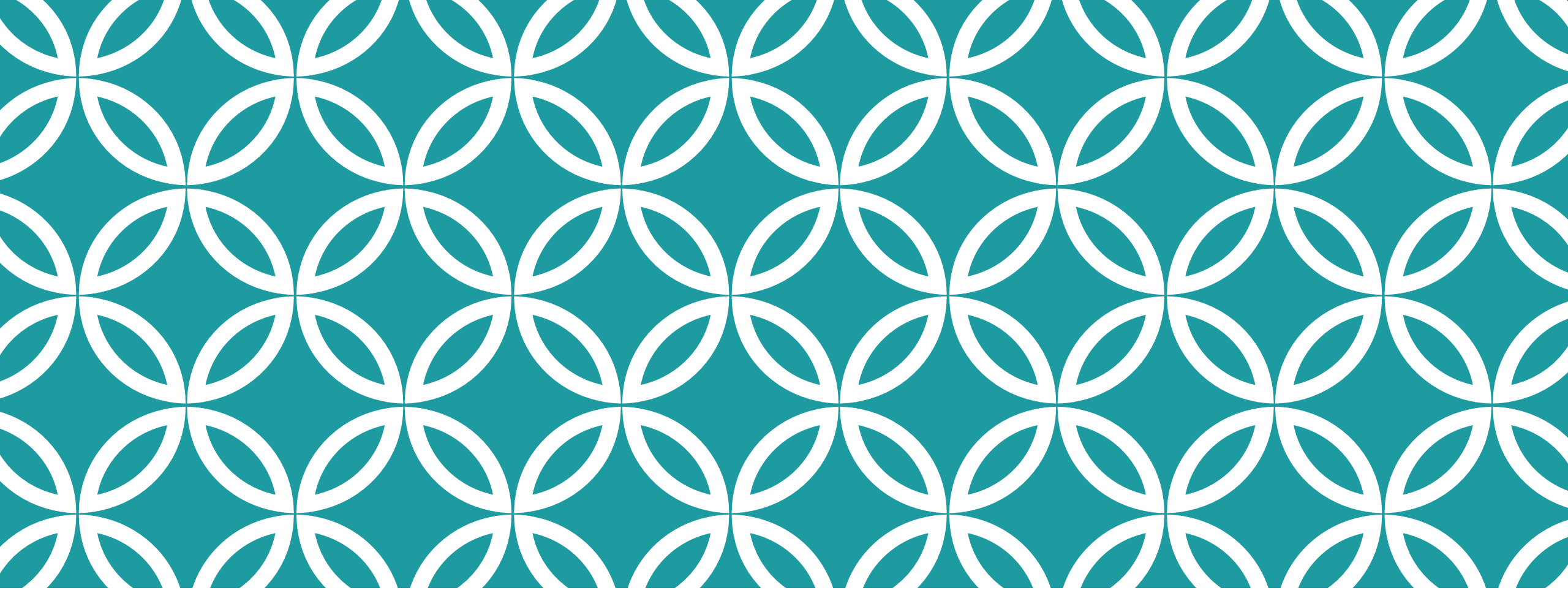
- Promotes autonomy
- Long-term benefits
- "Feels right"

Cons:

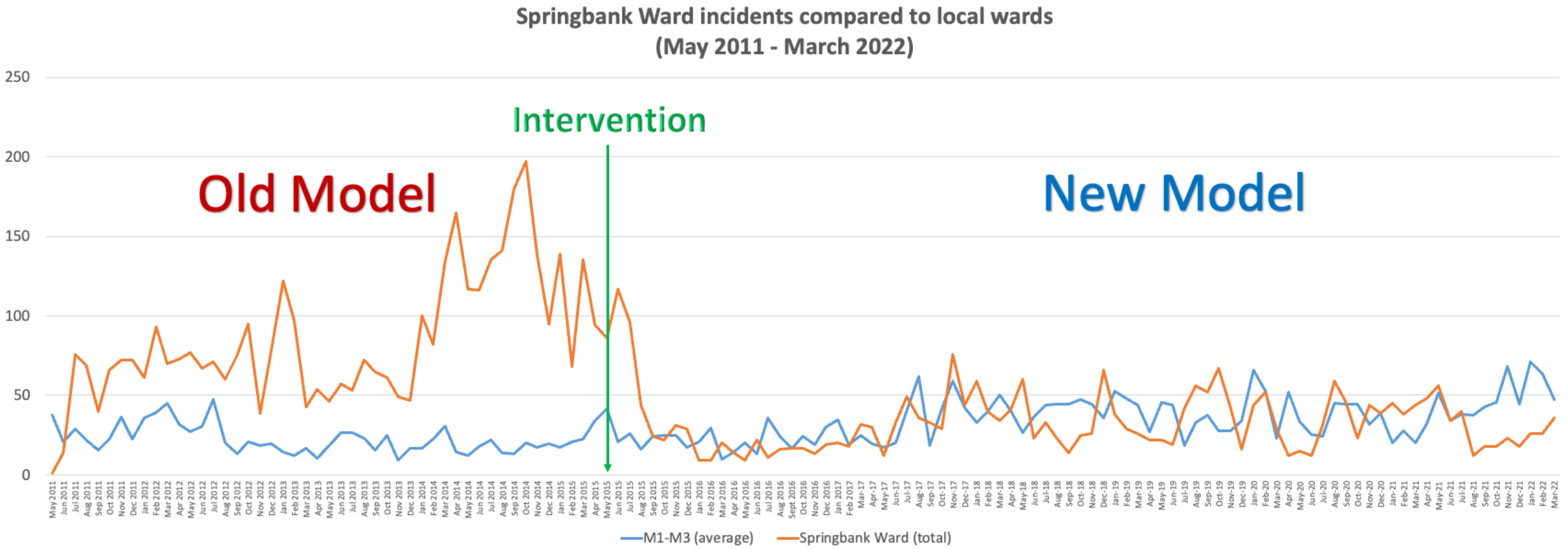
- Short-term risks
- Perceived as neglect
- Anxiety-provoking

MULTIPLE INITIATIVES





OUTCOMES

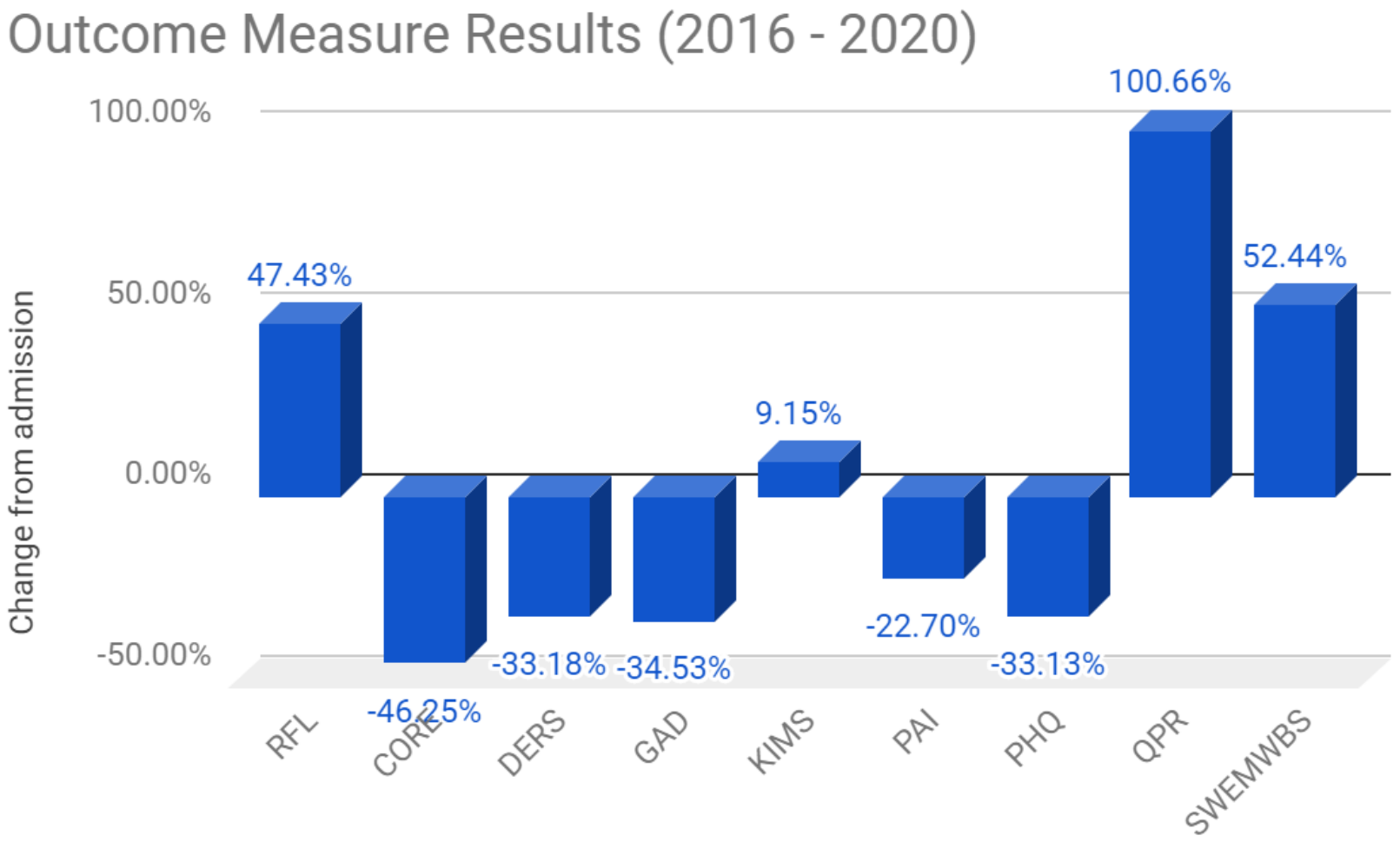


Average incidents per month	Old model (2011 – 2015)	New Model (2015 – 2022)	Change
M1 - M3	23.0	34.9	52%
Springbank	84.9	33.1	-61%

PHYSICAL INTERVENTIONS

Year	Number of incidents requiring physical intervention	Number of incidents requiring rapid tranquilisation
2012	52	36
2013	57	45
2014	59	44
2015	64	18
2016	3	0
2017	4	0
2018	5	1
2019	1	1
2020	0	0
2021	0	0
2022	0	0

DIFFERENCE BETWEEN ADMISSION AND DISCHARGE

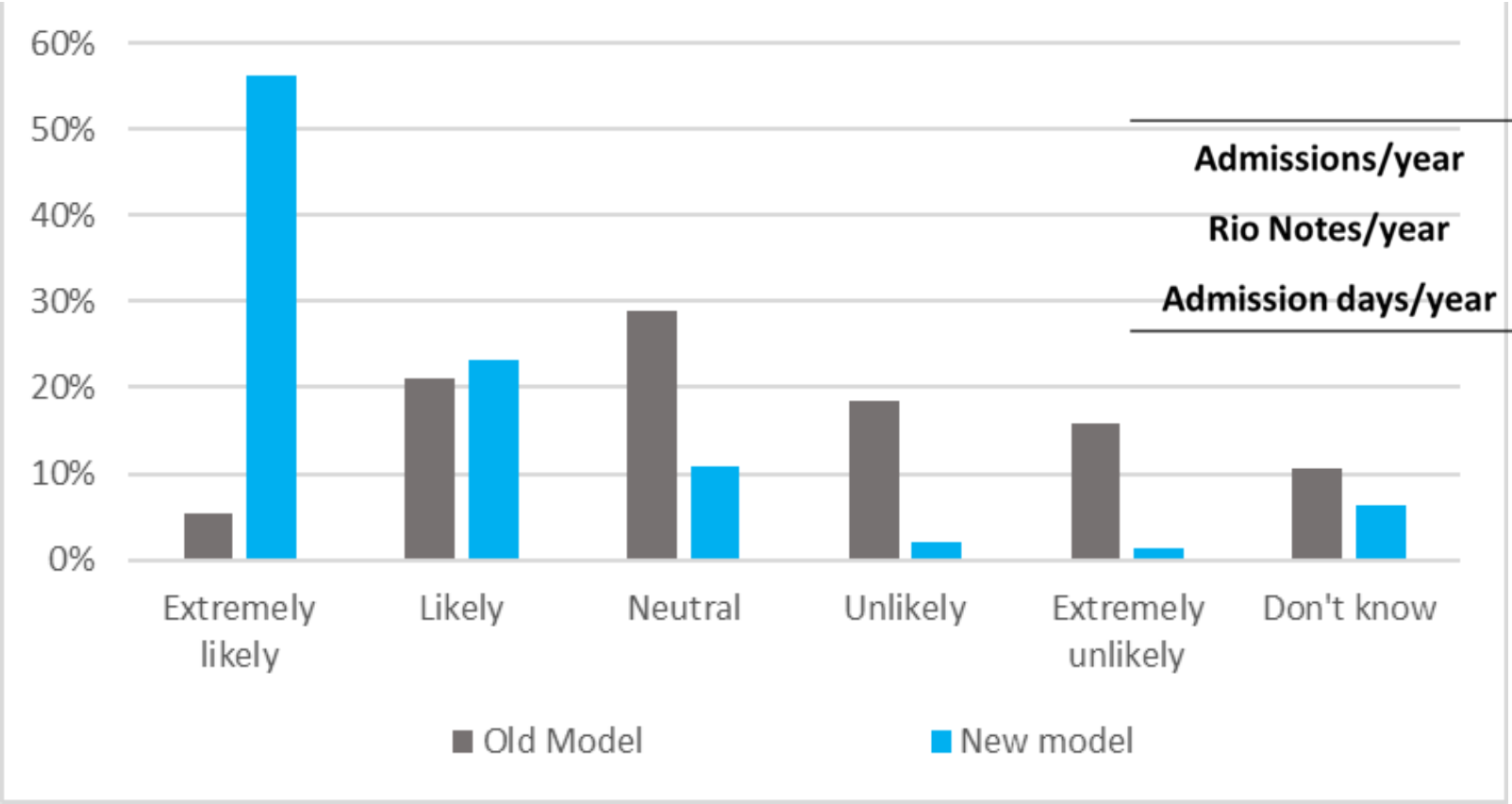


All outcome measures indicate an improvement compared to admission.

VALUE

Increased patient satisfaction and service use reduction

"Would you recommend this service to friends and family?"



	Before	After	Change
Admissions/year	5.4	0.5	-90%
Rio Notes/year	292	109	-59%
Admission days/year	41.0	1.9	-95%

STAFF'S EXPERIENCE

Increased job satisfaction

Richer therapeutic relationships

Better reputation

- Less vacancies
- Stable team
- Students!

WARD REPUTATION

RCPsych Awards 2019

Nominated for 'Team of the year'

https://www.bbc.co.uk/news/health-47393050

Winner: Cambridgeshire and Peterborough FT - Abolishing restrictive interventions at Springbank Ward, specialist personality disorder unit

https://awards.hsj.co.uk/winners-2020

PUBLICATIONS

› Psychiatr Danub. 2019 Sep;31(Suppl 3):626-631.

Attitudes towards a borderline personality disorder unit – a small-scale qualitative survey

Jakub Nagrodzki [1], Jorge Zimbron

Affiliations + expand

PMID: 31488804

Rethinking Risk Assessments in a Borderline Personality Disorder Unit: Patient and Staff Perspectives

Owen A. Crawford [1, 2], Tahir S. Khan [1, 2], Jorge Zimbron [1]

1. Springbank Ward, Fulbourn Hospital, Cambridgeshire and Peterborough NHS Foundation Trust, Cambridge, GBR 2. School of Clinical Medicine, University of Cambridge, Cambridge, GBR

Corresponding author: Owen A. Crawford, owen.crawford@outlook.com

Case Report

Treatment of Severe Emotionally Unstable Personality Disorder with Comorbid Ehlers-Danlos Syndrome and Functional Neurological Disorder in an Inpatient Setting: A Case for Specialist Units without Restrictive Interventions

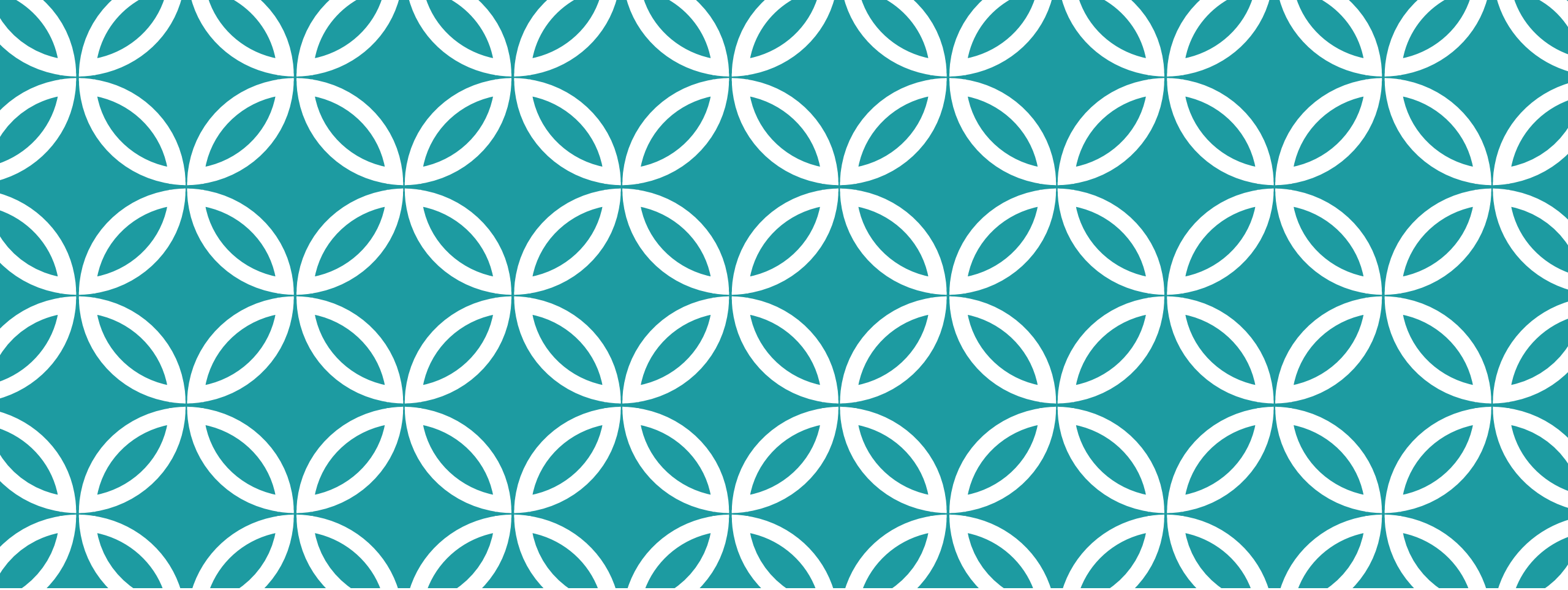
Jessica Henry,[1] Eddie Collins,[2] Amanda Griffin,[3] and Jorge Zimbron[3]

[1]University of Cambridge School of Clinical Medicine, Addenbrooke's Hospital, Hills Rd, Cambridge CB2 0SP, UK
[2]Somerset Partnership NHS Foundation Trust, Bridgwater TA6 4RN, UK
[3]Springbank Ward, Cambridgeshire and Peterborough Mental Health Partnership NHS Trust, Fulbourn, Cambridge CB21 5EF, UK

Correspondence should be addressed to Jessica Henry

Received 8 December 2020; Revised 16 February 2021; Accepted 18 February 2021

Academic Editor: Lut Tamam



SPRINGBANK PARALLELS

INPATIENT TRIALS

RCT 1999

- Partial hospitalization vs TAU
- N=38

18m programme

Improvements in symptoms, self-harm, suicide attempts, inpatient days, functic in inpatient group.

Ongoing improvement after 18m

The American Journal of Psychiatry REGULAR ARTICLE

Effectiveness of Partial Hospitalization in the Treatment of Borderline Personality Disorder: A Randomized Controlled Trial

Anthony Bateman, M.A., F.R.C.Psych. and Peter Fonagy, Ph.D., F.B.A.

OBJECTIVE: This study compared the effectiv
with standard psychiatric care for patients wi
patients with borderline personality disorder, dia
either to a partially hospitalized group or to a s
controlled design. Treatment, which included ind
maximum of 18 months. Outcome measures inc
harm, the number and duration of inpatient admi
measures of depression, anxiety, general sympt
Data analysis used repeated measures analysis
Patients who were partially hospitalized showe
contrast to the control group, which showed li
improvement in depressive symptoms, a decre
days, and better social and interpersonal func
treatment at 18 months. **CONCLUSIONS:** Psyc
standard psychiatric care for patients with borde
groups, but these results suggest that partial hos

1999; 156:1563-1569
https://doi.org/10.1176/ajp.156.10.1563

The American Journal of Psychiatry ARTICLE

Treatment of Borderline Personality Disorder With Psychoanalytically Oriented Partial Hospitalization: An 18-Month Follow-Up

Anthony Bateman, M.A., F.R.C.Psych. and Peter Fonagy, Ph.D., F.B.A.

OBJECTIVE: The aim of this study was to determine whether the substantial gains made by patients with borderline personality disorder following completion of a psychoanalytically oriented partial hospitalization program, in comparison to patients treated with standard psychiatric care, were maintained over an 18-month follow-up period. **METHOD:** Forty-four patients who participated in the original study were assessed every 3 months after completion of the treatment phase. Outcome measures included frequency of suicide attempts and acts of self-harm, number and duration of inpatient admissions, service utilization, and self-reported measures of depression, anxiety, general symptom distress, interpersonal functioning, and social adjustment. **RESULTS:** Patients who completed the partial hospitalization program not only maintained their substantial gains but also showed a statistically significant continued improvement on most measures in contrast to the patients treated with standard psychiatric care, who showed only limited change during the same period. **CONCLUSIONS:** The superiority of psychoanalytically oriented partial hospitalization over standard psychiatric treatment found in a previous randomized, controlled trial was maintained over an 18-month follow-up period. Continued improvement in social and interpersonal functioning suggests that longer-term changes were stimulated.

2001; 158:36-42
https://doi.org/10.1176/appi.ajp.158.1.36

INPATIENT TRIALS

Controlled trial 2004

Inpatient DBT for 3 months vs waiting list

N=50 women

Significant improvements in symptoms, self-harm, and functioning in the inpatient group.

ELSEVIER

Behaviour Research and Therapy 42 (2004) 487–499

BEHAVIOUR RESEARCH AND THERAPY

www.elsevier.com/locate/brat

Effectiveness of inpatient dialectical behavioral therapy for borderline personality disorder: a controlled trial

Martin Bohus [a,*], Brigitte Haaf [a], Timothy Simms [a], Matthias F. Limberger [a], Christian Schmahl [a], Christine Unckel [a], Klaus Lieb [a], Marsha M. Linehan [b]

[a] *Department of Psychiatry and Psychotherapy with Polyclinic, Albert-Ludwig-University of Freiburg, Medical School, Hauptstrasse 5, D-79104 Freiburg, Germany*

[b] *Department of Psychology, University of Washington, Seattle, WA, USA*

Received 15 November 2002; received in revised form 5 June 2003; accepted 11 June 2003

INPATIENT TRIALS

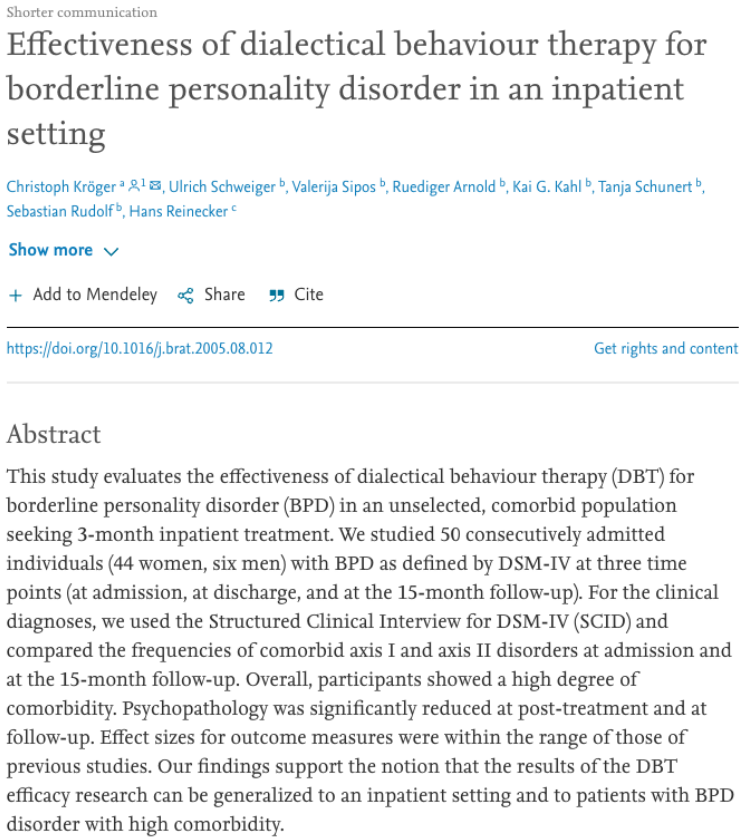
Case series

N=50

Inpatient DBT for 3 months

15m f/u

Improvements in psychopathology



Shorter communication

Effectiveness of dialectical behaviour therapy for borderline personality disorder in an inpatient setting

Christoph Kröger [a], Ulrich Schweiger [b], Valerija Sipos [b], Ruediger Arnold [b], Kai G. Kahl [b], Tanja Schunert [b], Sebastian Rudolf [b], Hans Reinecker [c]

Show more

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https://doi.org/10.1016/j.brat.2005.08.012

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Abstract

This study evaluates the effectiveness of dialectical behaviour therapy (DBT) for borderline personality disorder (BPD) in an unselected, comorbid population seeking 3-month inpatient treatment. We studied 50 consecutively admitted individuals (44 women, six men) with BPD as defined by DSM-IV at three time points (at admission, at discharge, and at the 15-month follow-up). For the clinical diagnoses, we used the Structured Clinical Interview for DSM-IV (SCID) and compared the frequencies of comorbid axis I and axis II disorders at admission and at the 15-month follow-up. Overall, participants showed a high degree of comorbidity. Psychopathology was significantly reduced at post-treatment and at follow-up. Effect sizes for outcome measures were within the range of those of previous studies. Our findings support the notion that the results of the DBT efficacy research can be generalized to an inpatient setting and to patients with BPD disorder with high comorbidity.

INPATIENT TRIALS

Case series

N=45

Day patient MBT for 18m

Improvements in psychopathology, functioning, service use, suicide attempts and self-harm.

Treatment Outcome of 18-Month, Day Hospital Mentalization-Based Treatment (MBT) in Patients with Severe Borderline Personality Disorder in the Netherlands

Dawn Bales, Nicole van Beek, Maaike Smits, Sten Willemsen, Jan J. V. Busschbach, Roel Verheul and Helene Andrea

Published Online: August 2012 • https://doi.org/10.1521/pedi.2012.26.4.568

PDF PDF PLUS Share Tools

Abstract

Psychoanalytically oriented day hospital therapy, later manualized and named mentalization-based treatment (MBT), has proven to be a (cost-) effective treatment for patients with severe borderline personality disorder and a high degree of psychiatric comorbidity (BPD) in the United Kingdom (UK). As to yet it has not been shown whether manualized day hospital MBT would yield similar results when conducted by an independent institute outside the UK. We investigated the applicability and treatment outcome of 18-month, manualized day hospital MBT in the Netherlands by means of a prospective cohort study with 45 Dutch patients with severe BPD and a high degree of comorbid Axis I and Axis II disorders. Outcomes were assessed each six months. Symptom distress, social and interpersonal functioning, and personality pathology and functioning all improved significantly, with effect sizes between 0.7 and 1.7. Suicide attempts, acts of self-harm, and care consumption were also significantly reduced. The results indicate that MBT can effectively be implemented in an independent treatment institute outside the UK. This study also supports the clinical effectiveness of manualized day hospital MBT in patients with severe BPD and a high degree of psychiatric comorbidity.

INPATIENT TRIALS

Case series

N=245 vs 220 (reference group)

40 days admission (average)

BPD improved at a similar rate than reference group

Contents lists available at ScienceDirect

Journal of Affective Disorders

journal homepage: www.elsevier.com/locate/jad

Research paper

A naturalistic longitudinal study of extended inpatient treatment for adults with borderline personality disorder: An examination of treatment response, remission and deterioration☆

J. Christopher Fowler[a,b,c,*], Joshua D. Clapp[d], Alok Madan[a,b,c], Jon G. Allen[b], B. Christopher Frueh[e], Peter Fonagy[b,f], John M. Oldham[b]

[a] The Menninger Clinic, 12301 Main Street, Houston, TX 77035, United States
[b] Baylor College of Medicine, One Baylor Plaza, Houston, TX 77030, United States
[c] Houston Me
[d] University o
[e] University o
[f] University C

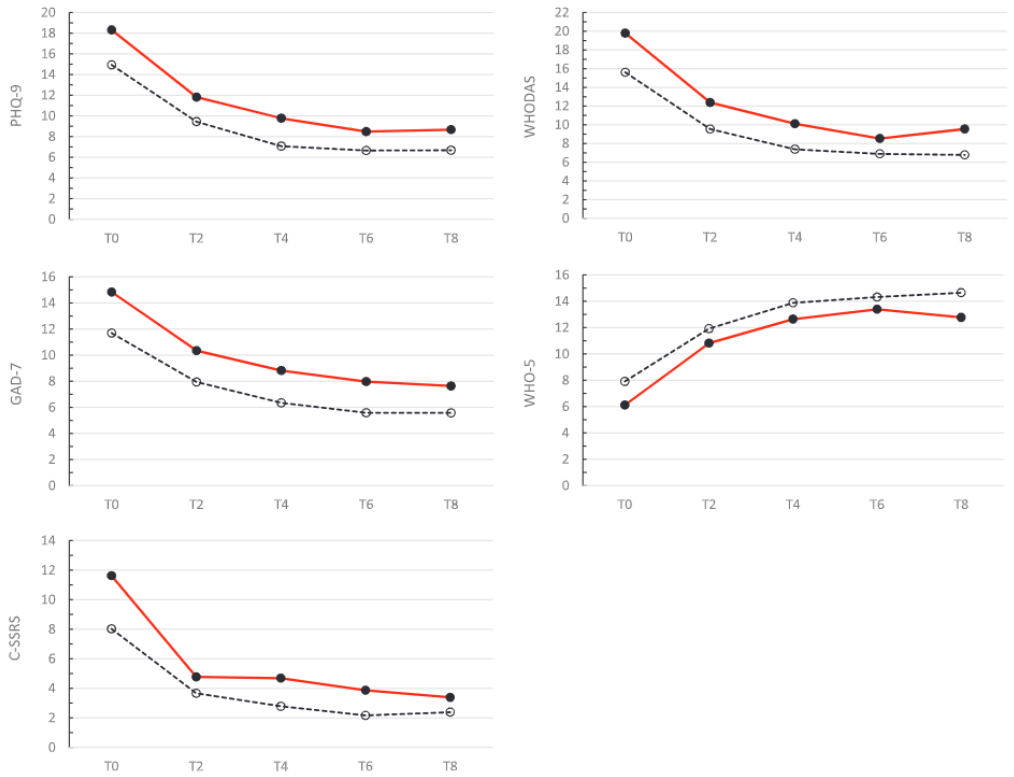


Fig. 1. Observed scores for reference and borderline personality disorder patients. (●——●) Borderline (○- - - - -○) Reference *Note*: PHQ-9 = Patient Health Questionnaire; GAD-7 = Generalized Anxiety Disorder 7-Item Scale; WHODAS = WHO Disability Assessment Schedule 2.0; WHO-5 = WHO Well-Being Index; C-SSRS = Columbia Suicide Severity Rating Scale – Ideation severity over the previous month.

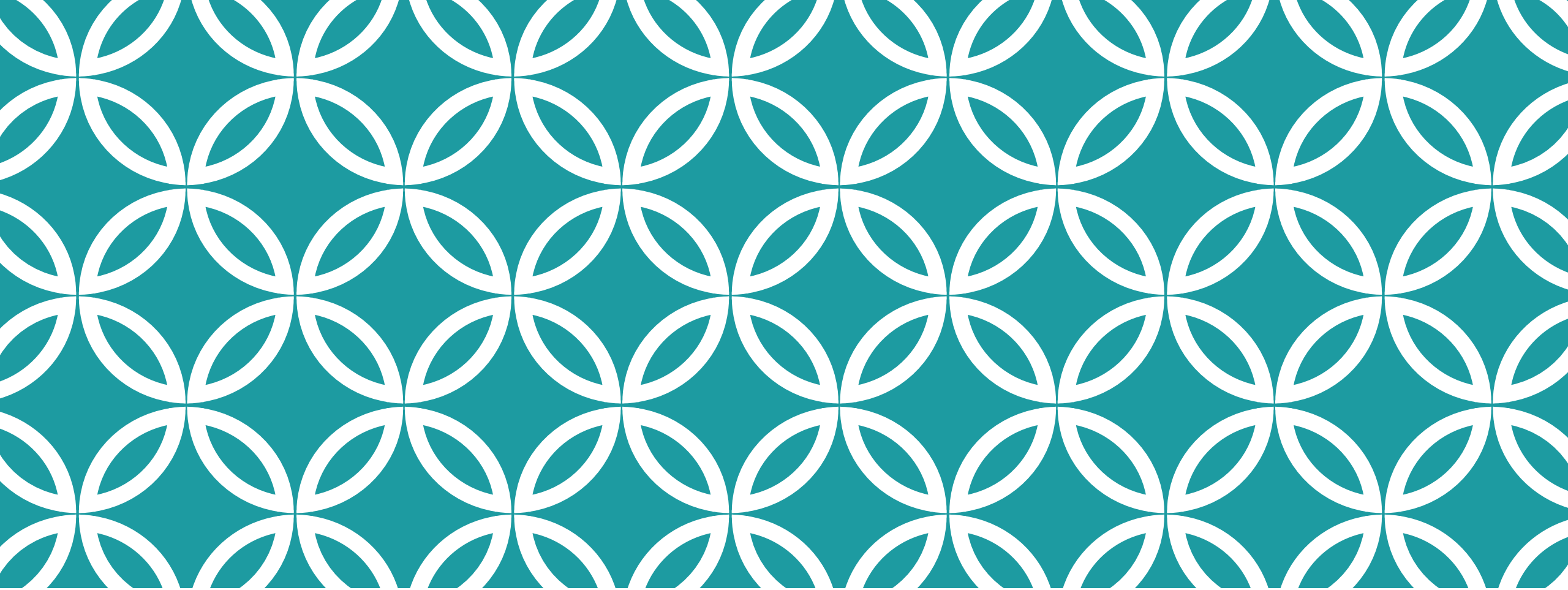
SIMILARITIES

High degree of co-morbidity

Use of medication

Non-restrictive environment

No evidence of the use of coercive treatment being helpful.



CONCLUSIONS

INSIGHTS

Values and clear boundaries

- Not rules

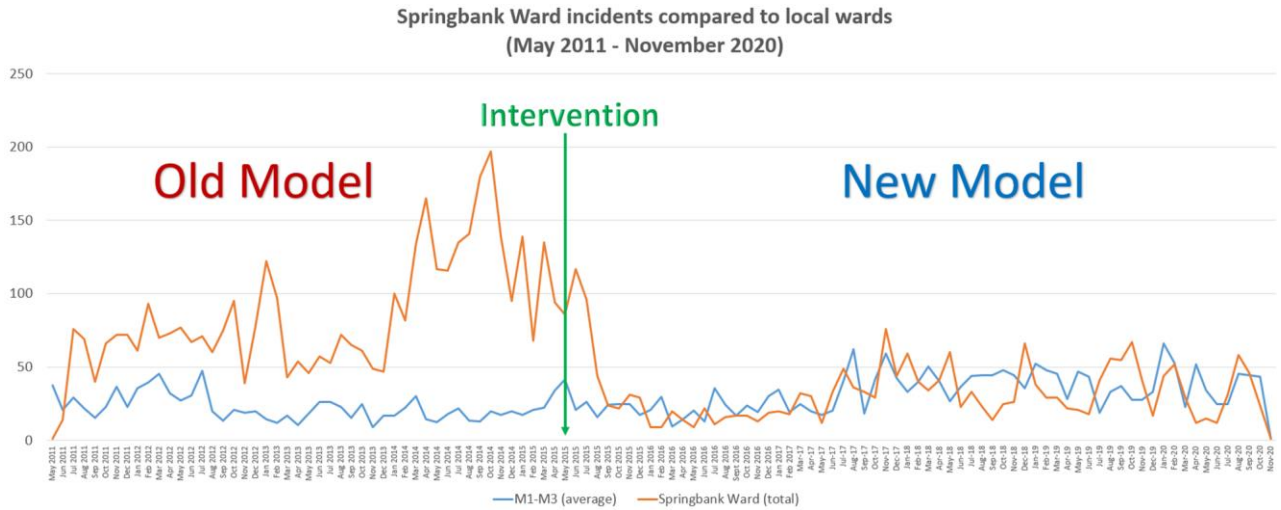
Courage, empathy, and compassion

- Safer than risk containment

Multi-disciplinary approach as a community

Co-production an constant change

Constant reflection about own behaviour



Restrictive admissions can be pointless and cause iatrogenic harm

There is no evidence supporting involuntary admissions for personality disorder

Admissions to the right environment can be helpful

Volume 2021 | Article ID 6615723 | https://doi.org/10.1155/2021/6615723

Show citation

Iatrogenic Complications of Compulsory Treatment in a Patient Presenting with an Emotionally Unstable Personality Disorder and Self-Harm

Charlotte Burrin,[1,2] Natasha Faye Daniels,[1,3] Rudolf N. Cardinal,[4,5] Catherine Hayhurst,[6] David Christmas,[4] and **Jorge Zimbron**[4]

Show more

Academic Editor: Toshiya Inada

Received	Revised	Accepted	Published
23 Oct 2020	26 Apr 2021	03 May 2021	27 May 2021

Abstract

Attempted suicide and deliberate self-harm are common and challenging presentations in the emergency department. A proportion of these patients refuse interventions and this presents the clinical, legal, and ethical dilemma as to whether treatment should be provided against their will. Multiple factors influence this decision. It is difficult to foresee the multitude and magnitude of complications that can arise once it has been decided to treat individuals who do not consent. This case illustrates a particularly

QUESTIONS?

The NHS Patient Safety Conference 2022: Breaking a culture of defensiveness

UP NEXT...

EIDO HEALTHCARE

Trusted Digital Consent

The NHS Patient Safety Conference 2022:
Breaking a culture of defensiveness

SPEAKING NOW

Joe Ali

National Account Manager
EIDO Healthcare

I will be discussing…

"Informed consent in the post Montgomery era"

Informed consent in the post Montgomery era

- Montgomery case (2015)
- GMC guidance on decision making and consent (2020)
- Impact of COVID-19 on patient information and patient decisions
- How digital technology can assist patients and clinicians

Mr Simon Parsons

EIDO HEALTHCARE
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Consultant General and Upper GI Surgeon at Nottingham University Hospitals NHS Trust

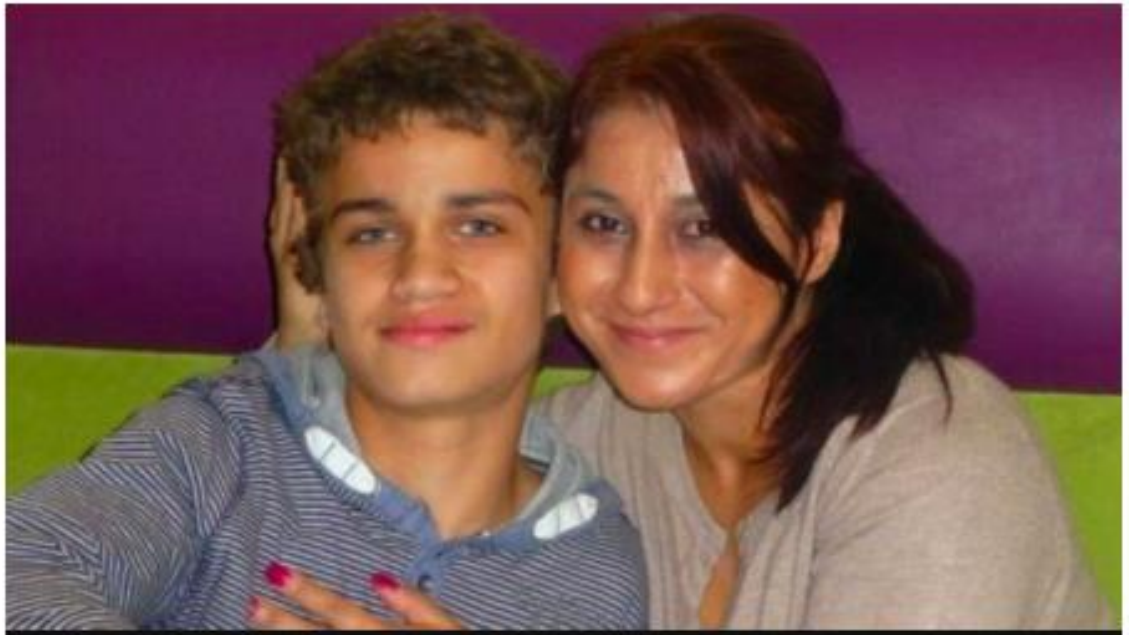
Associate Professor (Nottingham University)

Clinical Director of EIDO Healthcare Ltd.

Montgomery 2015

Nadine Montgomery wins £5m from NHS Lanarkshire over brain damage to son

11 March 2015 | Glasgow & West Scotland



Nadine Montgomery has won a 16-year legal fight for damages for her son Sam

A Lanarkshire woman whose baby suffered brain damage during birth has won a 16-year fight for £5.25m compensation.

Nadine Montgomery, 40, claimed medics neglected to give her proper advice which may have led to her son Sam having a safer caesarean birth in 1999.

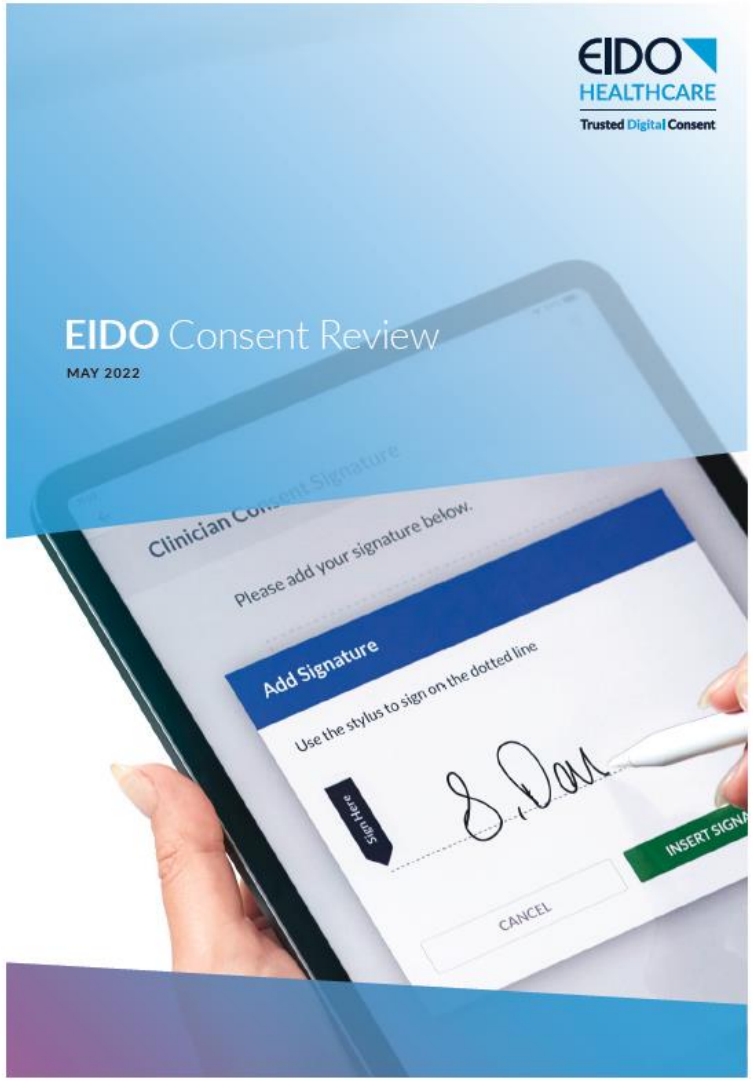
Reasonable patient

“Fundamental to the doctor and patient relationship is the requirement that a patient with capacity to decide should be informed about the treatment options open to him or her; the risks and benefits of each option; and be supported to make their choice about which treatment best meets their needs.”

Montgomery Ruling, 2015

EIDO Consent Review

Summary of Montgomery case and more recent legal cases



Contents

https://www.eidohealthcare.com/whitepapers/consent-review/

Guidance on professional standards and ethics for doctors

Decision making and consent

General Medical Council

Working with doctors Working for patients

Updated 2020 - 7 key principles

Principle **one**	All patients have the right to be involved in decisions about their treatment and care and be supported to make informed decisions if they are able.
Principle **two**	Decision making is an ongoing process focused on meaningful dialogue: the exchange of relevant information specific to the individual patient.
Principle **three**	All patients have the right to be listened to, and to be given the information they need to make a decision and the time and support they need to understand it.
Principle **four**	Doctors must try to find out what matters to patients so they can share relevant information about the benefits and harms of proposed options and reasonable alternatives, including the option to take no action.

Principles 5-7 relate to “capacity”

Information you give patients (GMC guidance paragraph 10)

General Medical Council

“You must” is an overriding duty or principle

You **must** give patients the information they want or need to make a decision. This will usually include:

a diagnosis and prognosis

b uncertainties about the diagnosis or prognosis, including options for further investigation

c options for treating or managing the condition, including the option to take no action

d the nature of each option, what would be involved, and the desired outcome

e the potential benefits, risks of harm, uncertainties about and likelihood of success for each option, including the option to
take no action.

INFORM CONSENT SUITE

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GMC Guidance states:
You must give patients clear, accurate and up to date information based on the best available evidence.

Inform content

Explanation of the problem

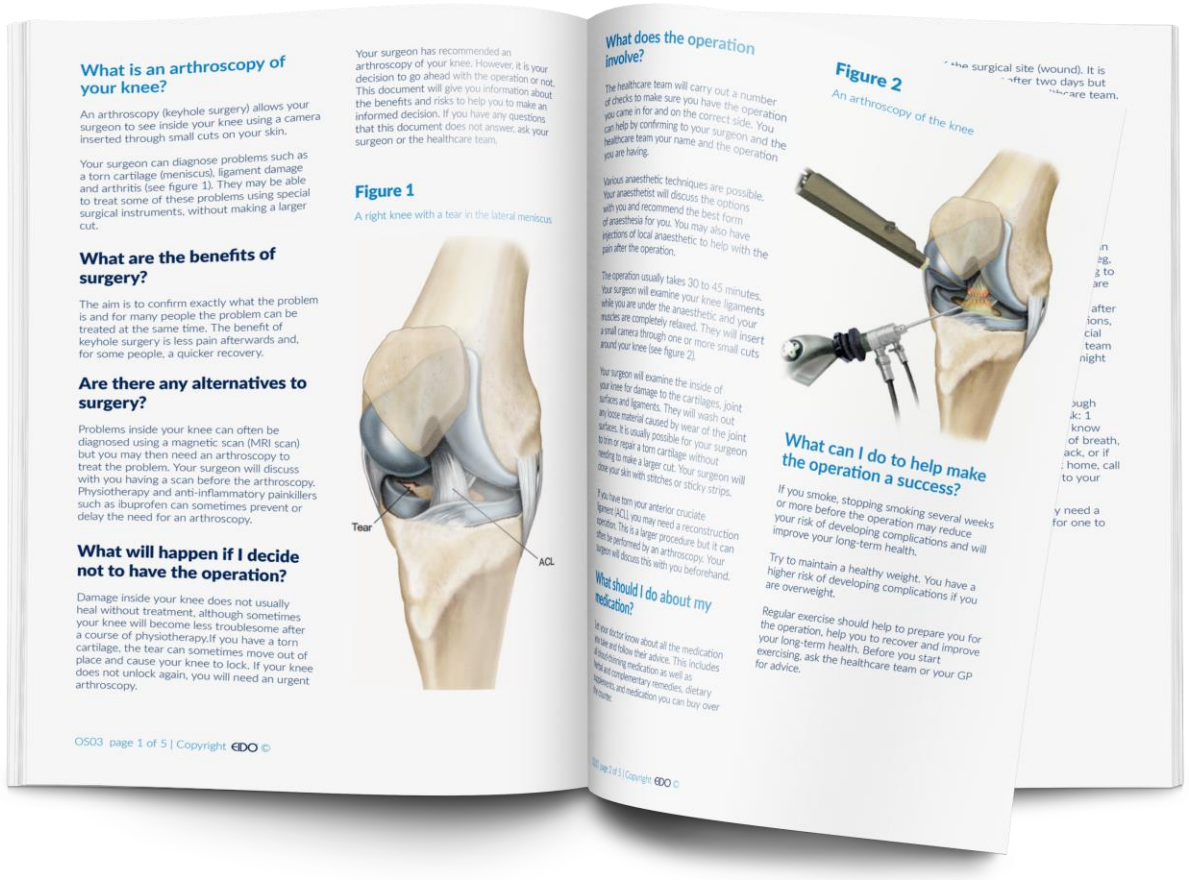
Treatment options (alternatives)

What the surgery involves

Risks and complications

Benefits & post op expectations

Lifestyle changes



What is an arthroscopy of your knee?

An arthroscopy (keyhole surgery) allows your surgeon to see inside your knee using a camera inserted through small cuts on your skin.

Your surgeon can diagnose problems such as a torn cartilage (meniscus), ligament damage and arthritis (see figure 1). They may be able to treat some of these problems using special surgical instruments, without making a larger cut.

What are the benefits of surgery?

The aim is to confirm exactly what the problem is and for many people the problem can be treated at the same time. The benefit of keyhole surgery is less pain afterwards and, for some people, a quicker recovery.

Are there any alternatives to surgery?

Problems inside your knee can often be diagnosed using a magnetic scan (MRI scan) but you may then need an arthroscopy to treat the problem. Your surgeon will discuss with you having a scan before the arthroscopy. Physiotherapy and anti-inflammatory painkillers such as ibuprofen can sometimes prevent or delay the need for an arthroscopy.

What will happen if I decide not to have the operation?

Damage inside your knee does not usually heal without treatment, although sometimes your knee will become less troublesome after a course of physiotherapy. If you have a torn cartilage, the tear can sometimes move out of place and cause your knee to lock. If your knee does not unlock again, you will need an urgent arthroscopy.

Your surgeon has recommended an arthroscopy of your knee. However, it is your decision to go ahead with the operation or not. This document will give you information about the benefits and risks to help you to make an informed decision. If you have any questions that this document does not answer, ask your surgeon or the healthcare team.

Figure 1

A right knee with a tear in the lateral meniscus

Tear

ACL

OS03 page 1 of 5 | Copyright EIDO ©

What does the operation involve?

The healthcare team will carry out a number of checks to make sure you have the operation you came in for and on the correct side. You can help by confirming to your surgeon and the healthcare team your name and the operation you are having.

Various anaesthetic techniques are possible. Your anaesthetist will discuss the options with you and recommend the best form of anaesthesia for you. You may also have injections of local anaesthetic to help with the pain after the operation.

The operation usually takes 30 to 45 minutes. Your surgeon will examine your knee ligaments while you are under the anaesthetic and your muscles are completely relaxed. They will insert a small camera through one or more small cuts around your knee (see figure 2).

Your surgeon will examine the inside of your knee for damage to the cartilages, joint surfaces and ligaments. They will wash out any loose material caused by wear of the joint surfaces. It is usually possible for your surgeon to trim or repair a torn cartilage without needing to make a larger cut. Your surgeon will close your skin with stitches or sticky strips.

If you have torn your anterior cruciate ligament (ACL) you may need a reconstruction operation. This is a larger procedure but it can often be performed by an arthroscopy. Your surgeon will discuss this with you beforehand.

What should I do about my medication?

Let your doctor know about all the medication you take and follow their advice. This includes all bloodthinning medication as well as herbal and complementary remedies, dietary supplements, and medication you can buy over the counter.

Figure 2

An arthroscopy of the knee

What can I do to help make the operation a success?

If you smoke, stopping smoking several weeks or more before the operation may reduce your risk of developing complications and will improve your long-term health.

Try to maintain a healthy weight. You have a higher risk of developing complications if you are overweight.

Regular exercise should help to prepare you for the operation, help you to recover and improve your long-term health. Before you start exercising, ask the healthcare team or your GP for advice.

Supporting patients' decision making (GMC guidance paragraph 27-30)

General Medical Council

Patients need relevant information (see paragraph 10) to be shared in a way they can understand and retain, so they can use it to make a decision.
Including - share it in a format they prefer - written, audio, translated, pictures or other media or methods

para 30
You **must** check whether patients have understood the information they have been given, and if they would like more information before making a decision.

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Other formats

Foreign language versions

Accessible versions:
easy-read
large & giant print
screen reader
animations
videos

TEAM

consistent information across your team

Delegated consent (GMC guidance paragraph 43-44)

General Medical Council

Support from other members of the healthcare team

- You must make sure the person you delegate to:
- is suitably trained and competent

  (formal informed consent training package)
- has sufficient knowledge of the intervention and its associated benefits and harms, as well as alternative options for treatment and care

  (written information documents)
- has the skills to have a dialogue with the patient that's in line with this guidance
- feels competent to carry out the delegated task and understands and agrees that they will refer to you (or another appropriate colleague) for further information, advice or support if necessary.

Medical records (GMC guidance Para 50-51)

General Medical Council

Patients' medical records

- 50 Keeping patients' medical records up to date with key information is important for continuity of care. **Keeping an accurate record of the exchange of information** leading to a decision in a patient's record will inform their future care and help you to explain and justify your decisions and actions.

- 51 You should take a proportionate approach to the level of detail you record. Good medical practice states that you must include the decisions made and actions agreed - and who is making the decisions and agreeing the actions - in the patient's clinical records. This includes decisions to take no action.

Reviewing decisions (GMC Guidance paragraph 56-58)

General Medical Council

Covid -19 changes risk balance
Long waiters may have consented before Covid-19

58 Reviewing a decision is particularly important:

if you haven't personally had a discussion with the patient because they were initially seen by a colleague

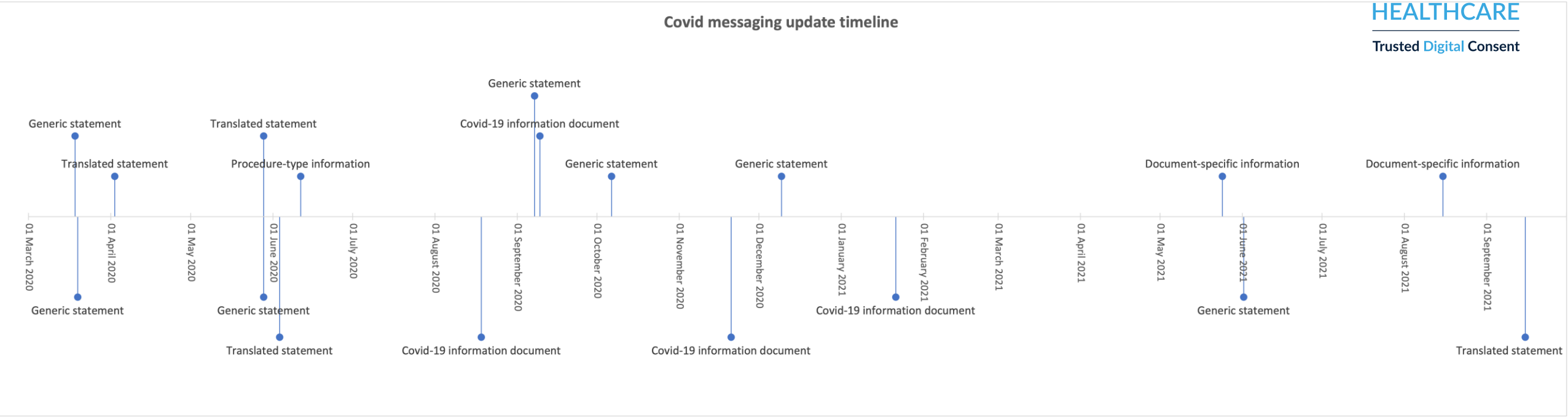
if significant time has passed since the decision was made

if the patient's condition has changed

if you have reason to believe the patient might have changed their mind

if any aspect of the chosen treatment or care has changed

if new information has become available about the potential benefits or risks of harm of any of the options that might make the patient choose differently.



March 2020

Sept 2021

EIDO Covid changes timeline

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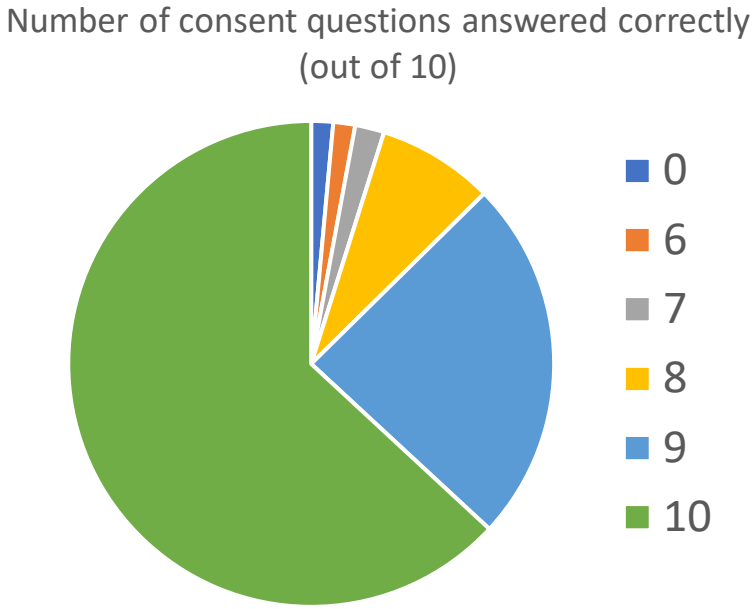
HOME CONSENT SOLUTIONS

eidohealthcare.com

“aboutmyop” Pilot data
Laparoscopic cholecystectomy

	n = (%)
Invited	898
Registered	349 (38.8)
All modules completed & report generated	203 (58.2)

		n = (%)
Gender F : M (%)		81.3 : 18.7
Age (years)	mean	46.7
	range	18-83



Time spent on consent e-learning:

Number of pts.	203
Mean	18.4 minutes
Median	17 minutes
Range	3 to 88 minutes

Digital consent process

EIDO HEALTHCARE
Trusted Digital Consent

Stage 1 - Learn at home

Stage 2 – Meaningful dialogue with clinician

Behind the scenes

Full Traceability

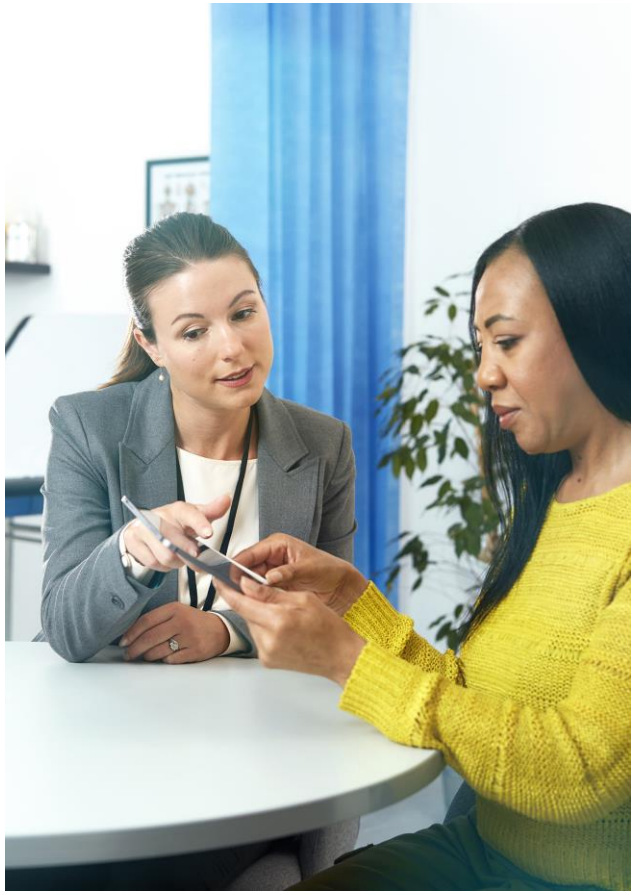
Full Documentation

Plain English

Chosen format

“What matters to this patient”

Medicolegal proof of informed consent



New developments

Operation and Patient specific risks with C2-AI

Avatars

Conclusions

Informed consent is a process which, if performed properly, promotes shared decision making.

The Law and the GMC Guidance make it quite clear what is expected of clinicians

Resources are available to help but they can't replace "meaningful dialogue"

Pt feedback from EIDO's digital pilot

"The process makes me feel responsible for making a good decision about my own healthcare"

Slido

Please scan the QR Code on the screen. This will take you through to Slido, where you can interact with us.

The NHS Patient Safety Conference 2022

SCAN ME

8th July 2022- 08:00am – 15:30pm – Mercure Manchester Piccadilly Hotel

Conference hosted by Convenzis Group Limited

The NHS Patient Safety Conference 2022: Breaking a culture of defensiveness

Q&A PANEL

Helen Hughes

CEO
Patient Safety Learning

Dr Jorge Zimbron

Consultant
Psychiatrist

Joe Ali

National Account Manager
EIDO Healthcare

Dr Sarah Kay

Joint Clinical Governance
Medical Lead

MORNING BREAK, NETWORKING & REFRESHMENTS

The NHS Patient Safety Conference 2022:
Breaking a culture of defensiveness

Chair Morning Reflection

Jane Walsh

Senior Improvement Advisor
Advancing Quality Alliance
(Aqua)

The NHS Patient Safety Conference 2022: Breaking a culture of defensiveness

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The NHS Patient Safety Conference 2022:
Breaking a culture of defensiveness

SPEAKING NOW

Chris Elkin

Head of Healthcare
Piota Healthcare Apps

I will be discussing…

"How the Piota app platform is being used to improve Patient Experience"

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Healthcare Apps
Inclusion through innovation

Chris Elkin

Head of Healthcare

chris.elkin@piota.co.uk | @chriselkin | 0770 1093733

Piota

Hello my name is Chris

- 20+ years within the digital media industry
- 10 years NHS experience
  - Producing online mandatory learning content/ systems
  - Learning passport and nurse re-validation apps
  - Trust website & intranet management
  - Digital communications and engagement
- Particular interest in the User Experience (UX)
  - “Making it easy…”
  - “Don’t make me think”

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A selection of our NHS cl

NHS Fife

NHS Chesterfield Royal Hospital NHS Foundation Trust

GIG CYMRU NHS WALES

NHS England

NHS West Hertfordshire Hospitals NHS Trust

NHS University Hospitals of Derby and Burton NHS Foundation Trust

NHS Frimley Health NHS Foundation Trust

NHS St Helens and Knowsley Teaching Hospitals NHS Trust

NHS University Hospitals Birmingham NHS Foundation Trust

NHS Buckinghamshire Healthcare NHS Trust

NHS Liverpool University Hospitals NHS Foundation Trust

NHS Grampian

NHS Birmingham Women's and Children's NHS Foundation Trust

NHS University Hospitals of Morecambe Bay NHS Foundation Trust

NHS Ayrshire & Arran

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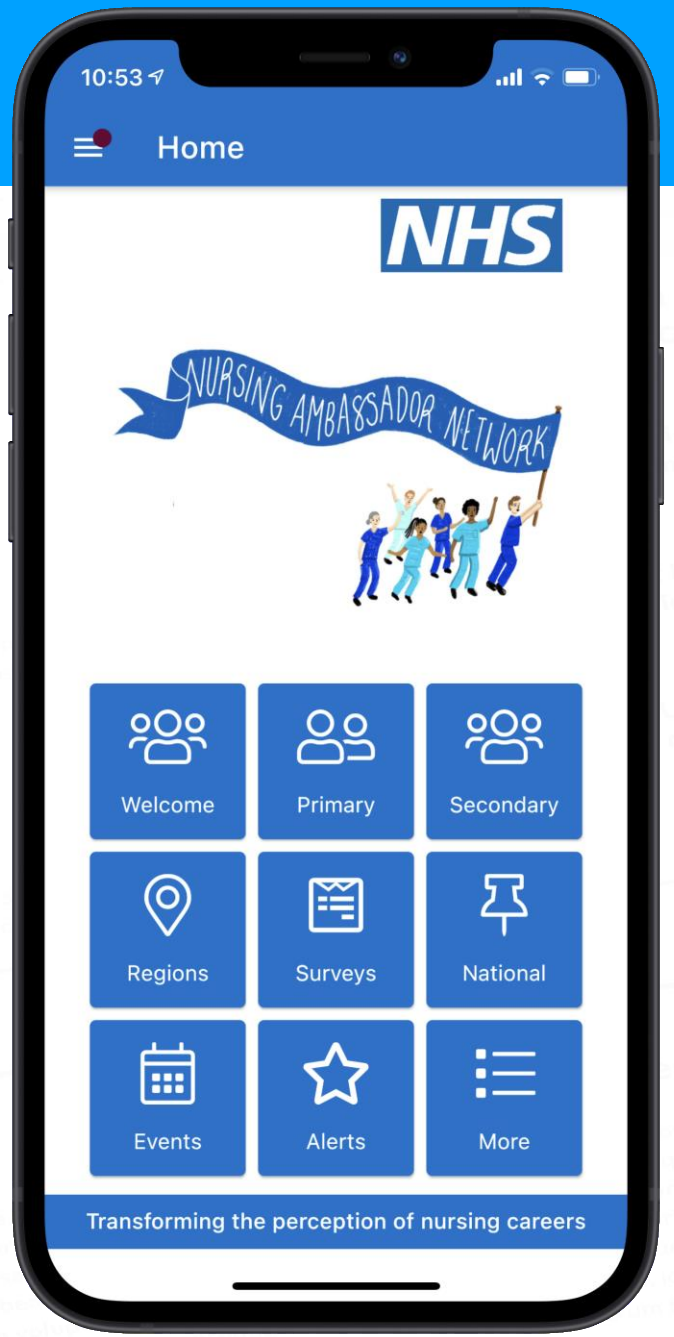
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Home
NHS
NURSING AMBASSADOR NETWORK
Welcome
Primary
Secondary
Regions
Surveys
National
Events
Alerts
More
Transforming the perception of nursing careers

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Making our working life's easier...

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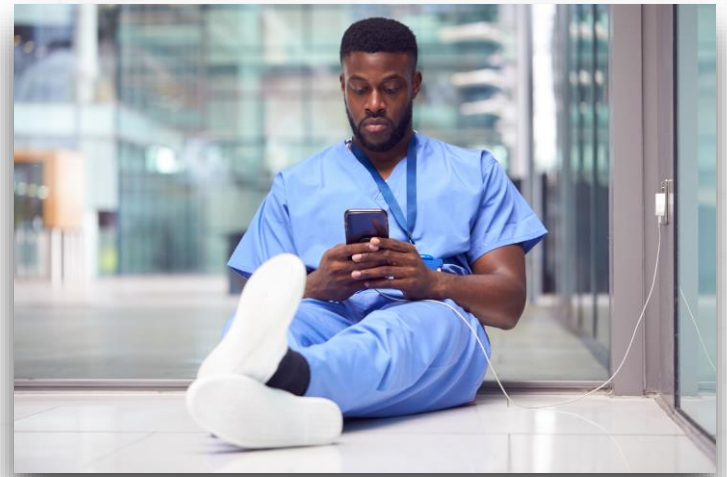
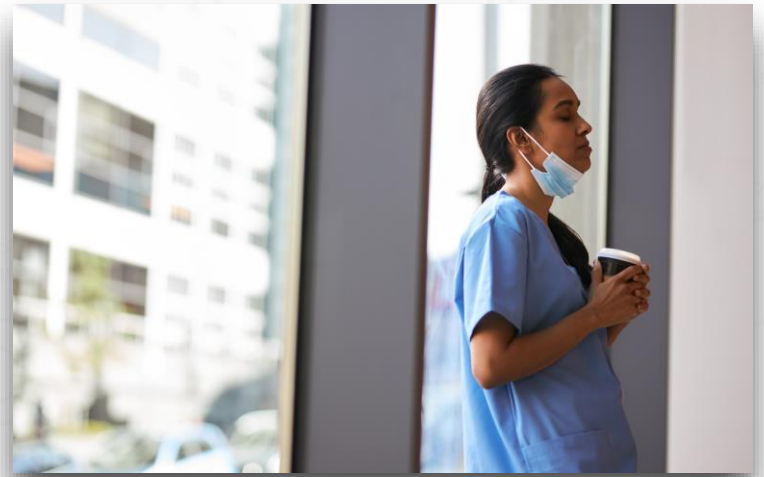
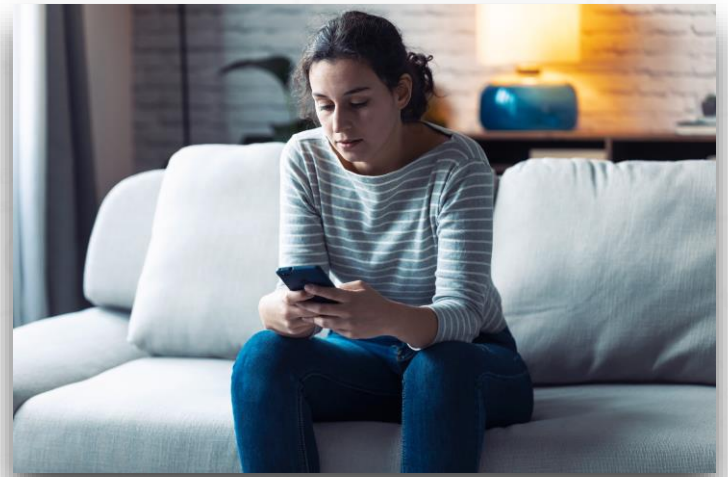
Look Familiar?

Providing information in a quick, easy, timely and targeted fashion







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Dudley Group NHS Foundation Trust

ED Team App

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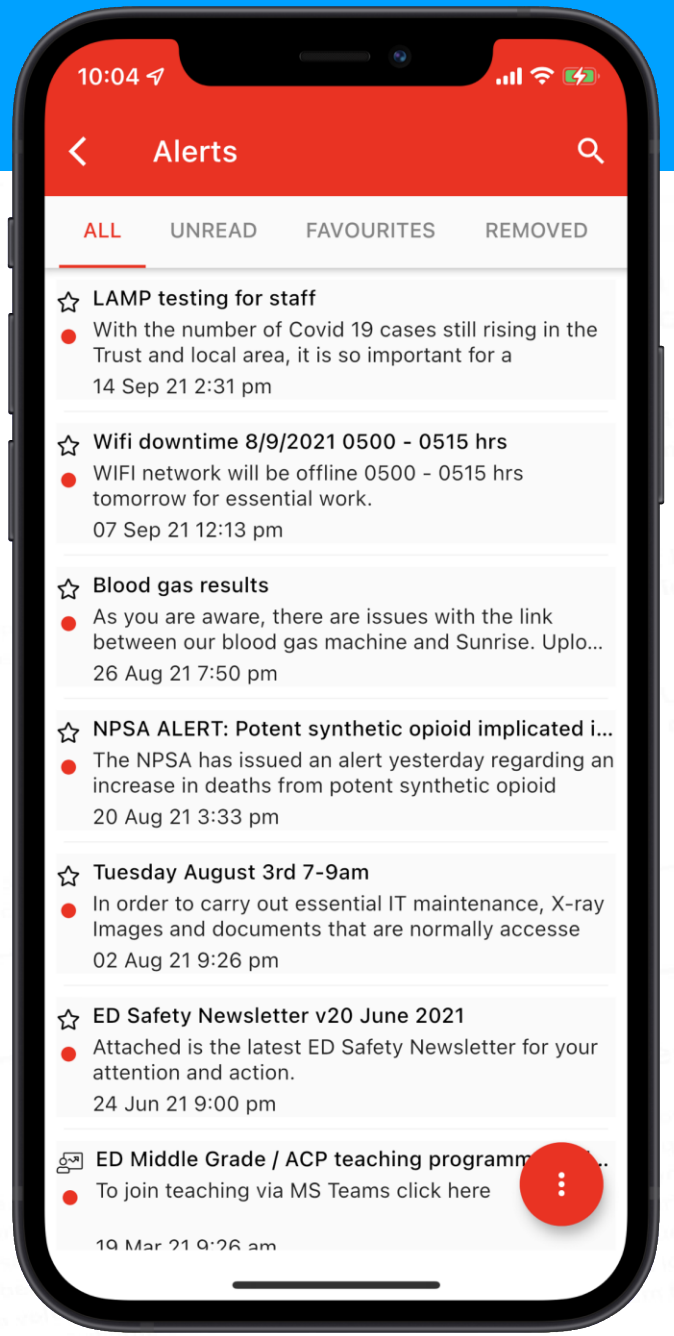
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Alerts
ALL
UNREAD
FAVOURITES
REMOVED
LAMP testing for staff
With the number of Covid 19 cases still rising in the Trust and local area, it is so important for a
14 Sep 21 2:31 pm
Wifi downtime 8/9/2021 0500 - 0515 hrs
WIFI network will be offline 0500 - 0515 hrs tomorrow for essential work.
07 Sep 21 12:13 pm
Blood gas results
As you are aware, there are issues with the link between our blood gas machine and Sunrise. Uplo...
26 Aug 21 7:50 pm
NPSA ALERT: Potent synthetic opioid implicated i...
The NPSA has issued an alert yesterday regarding an increase in deaths from potent synthetic opioid
20 Aug 21 3:33 pm
Tuesday August 3rd 7-9am
In order to carry out essential IT maintenance, X-ray Images and documents that are normally accesse
02 Aug 21 9:26 pm
ED Safety Newsletter v20 June 2021
Attached is the latest ED Safety Newsletter for your attention and action.
24 Jun 21 9:00 pm
ED Middle Grade / ACP teaching programm
To join teaching via MS Teams click here
19 Mar 21 9:26 am

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University Hospitals of Derby & Burton NHS Foundation Trust

FM & Estates App

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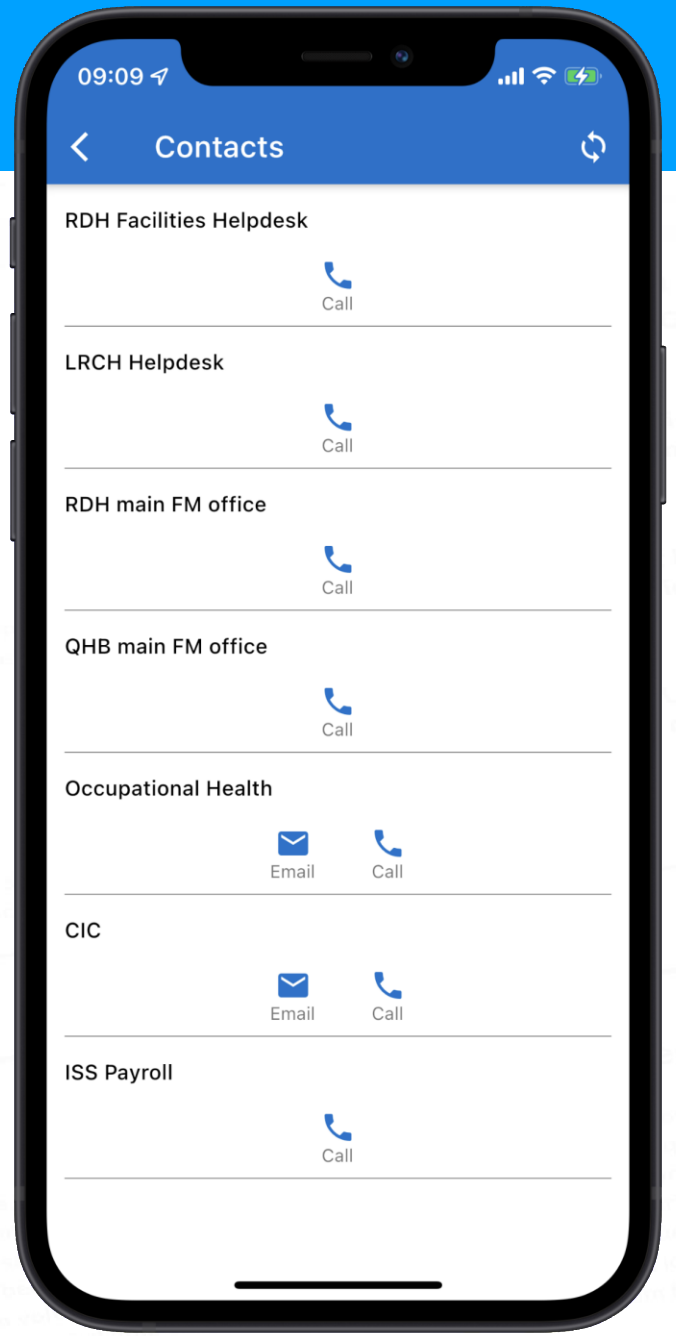
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Contacts
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Occupational Health
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ISS Payroll
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St. Helens & Knowsley Teaching Hospitals NHS Trust

Staff Communication & Wellbeing App

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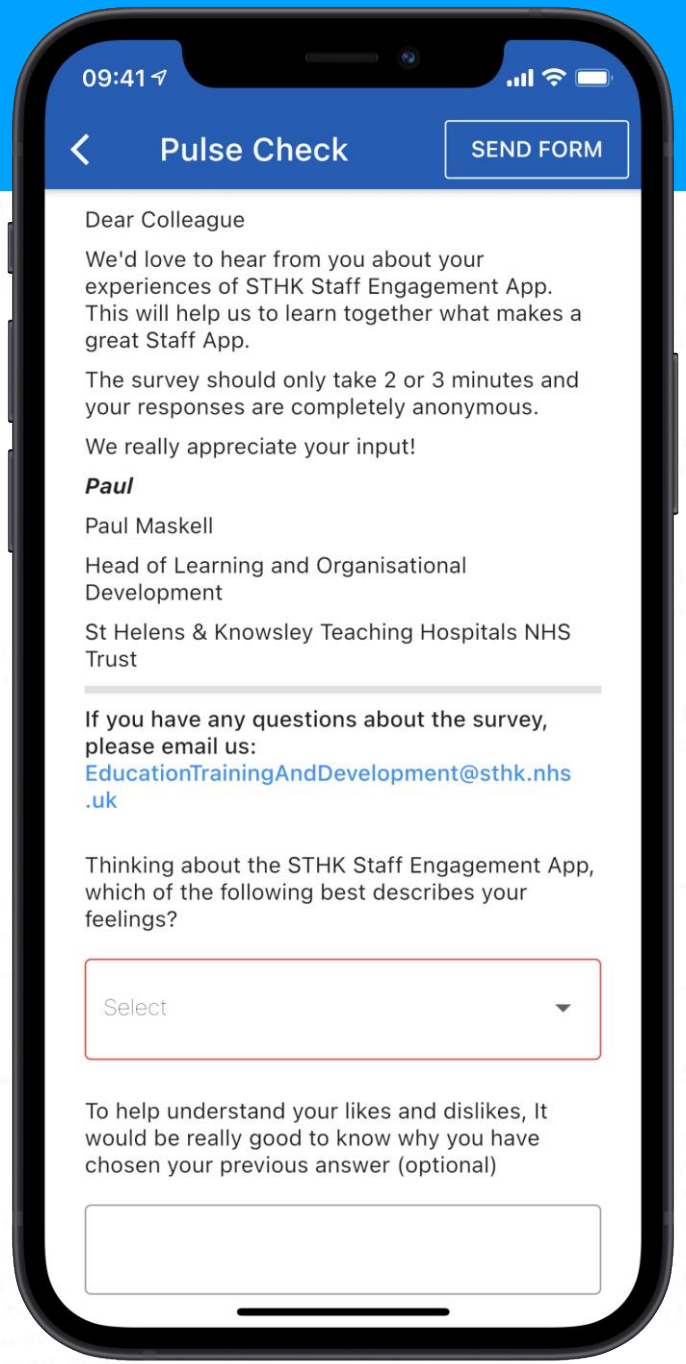
09:41
Pulse Check
SEND FORM
Dear Colleague
We'd love to hear from you about your experiences of STHK Staff Engagement App. This will help us to learn together what makes a great Staff App.
The survey should only take 2 or 3 minutes and your responses are completely anonymous.
We really appreciate your input!
Paul
Paul Maskell
Head of Learning and Organisational Development
St Helens & Knowsley Teaching Hospitals NHS Trust
If you have any questions about the survey, please email us: EducationTrainingAndDevelopment@sthk.nhs.uk
Thinking about the STHK Staff Engagement App, which of the following best describes your feelings?
Select
To help understand your likes and dislikes, It would be really good to know why you have chosen your previous answer (optional)

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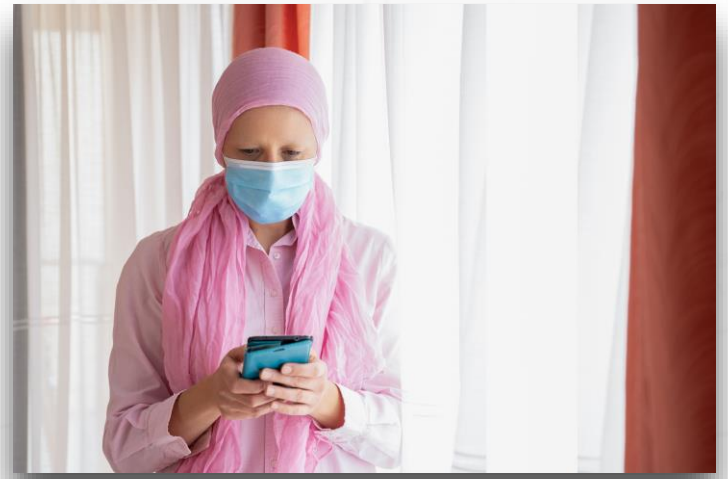
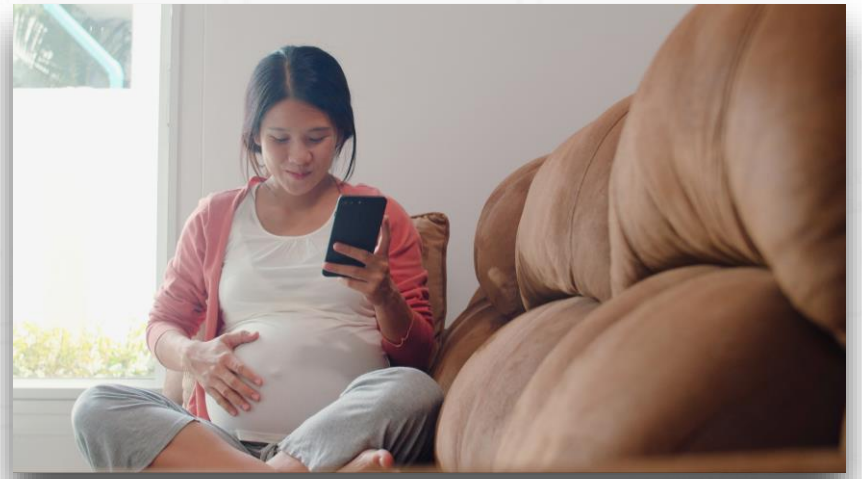
“Improving the Patient Experience”

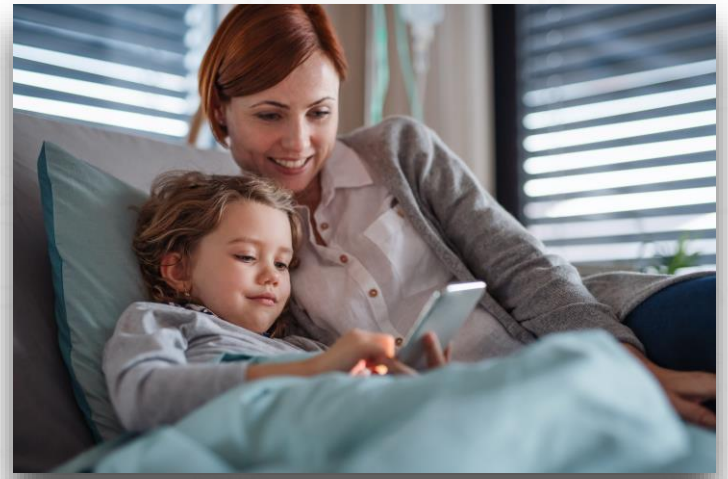
Piota

Improving the Patient Experience

Providing key, relevant & local information in a quick, easy, timely and targeted fashion





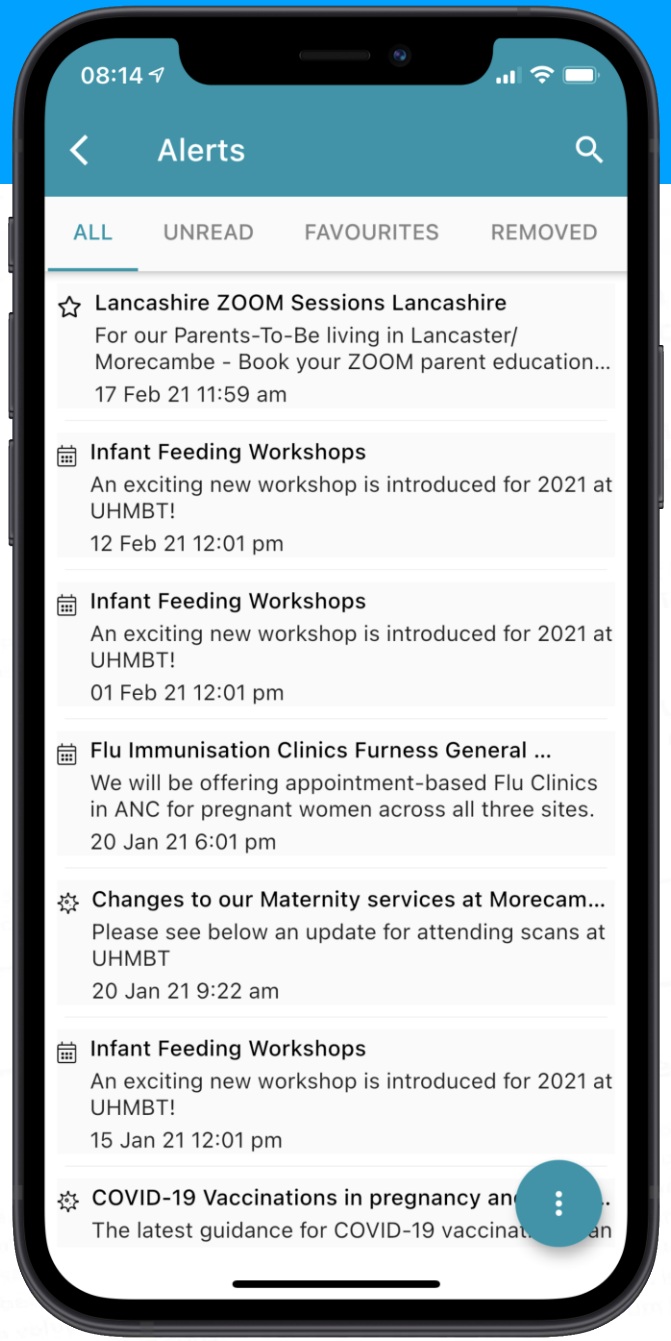


Piota

Morecambe Bay Hospital NHS Foundation Trust

Maternity Matters App

Piota


08:14
Alerts
ALL
UNREAD
FAVOURITES
REMOVED
Lancashire ZOOM Sessions Lancashire
For our Parents-To-Be living in Lancaster/ Morecambe - Book your ZOOM parent education...
17 Feb 21 11:59 am
Infant Feeding Workshops
An exciting new workshop is introduced for 2021 at UHMBT!
12 Feb 21 12:01 pm
Infant Feeding Workshops
An exciting new workshop is introduced for 2021 at UHMBT!
01 Feb 21 12:01 pm
Flu Immunisation Clinics Furness General ...
We will be offering appointment-based Flu Clinics in ANC for pregnant women across all three sites.
20 Jan 21 6:01 pm
Changes to our Maternity services at Morecam...
Please see below an update for attending scans at UHMBT
20 Jan 21 9:22 am
Infant Feeding Workshops
An exciting new workshop is introduced for 2021 at UHMBT!
15 Jan 21 12:01 pm
COVID-19 Vaccinations in pregnancy an
The latest guidance for COVID-19 vaccinat an

Piota

The Piota App Solution

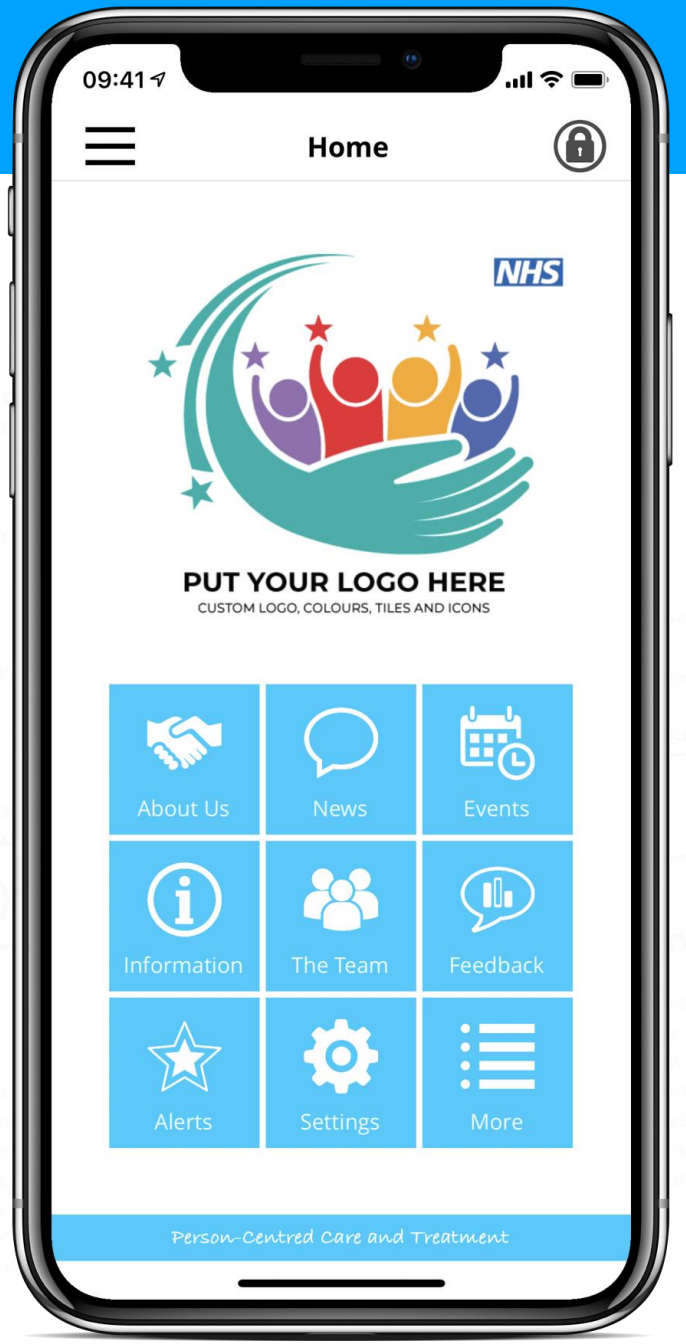
Piota

Piota = ‘Put it on the App’

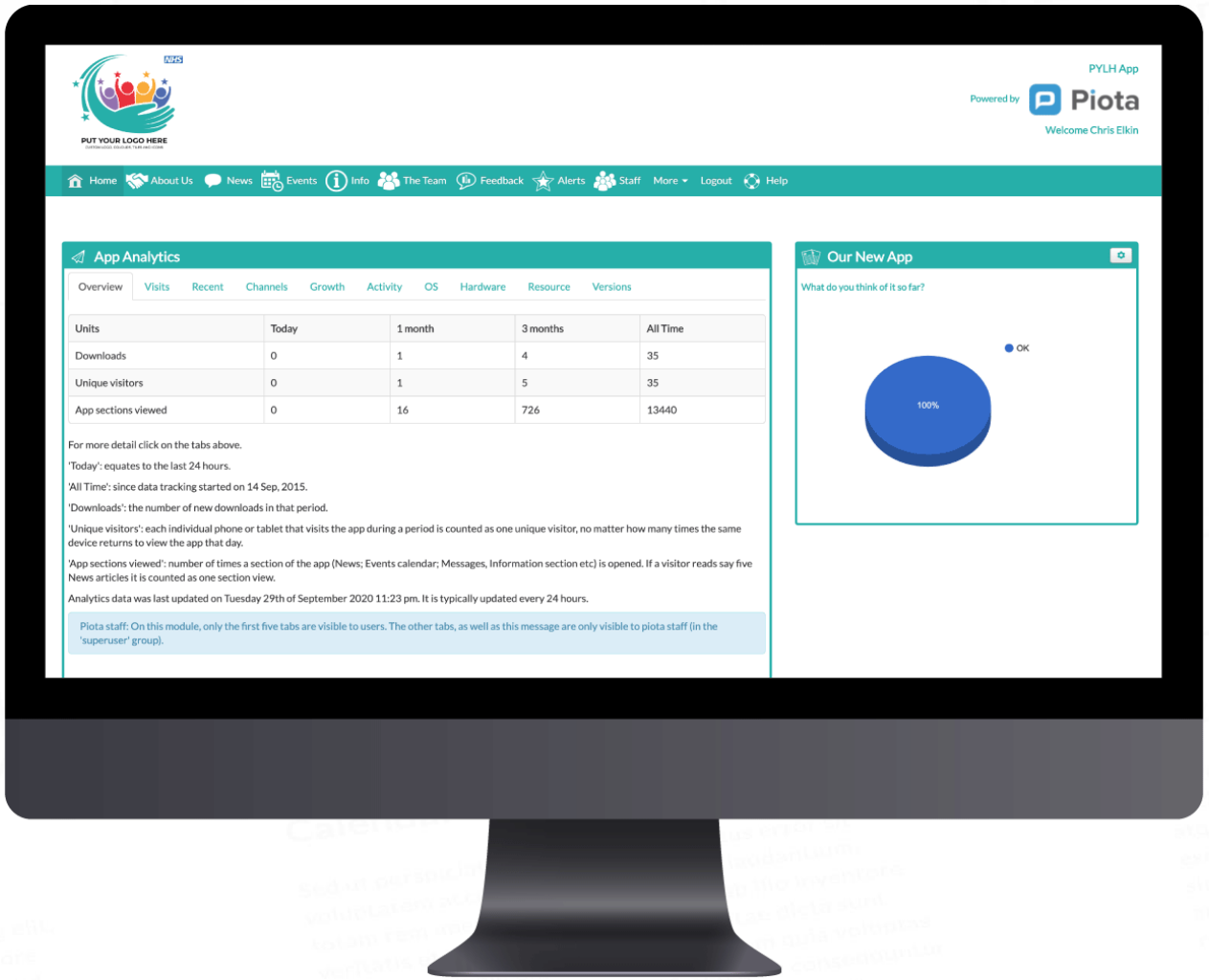
- Audience specific content (Open, restricted, groups, individual)
- Information / Resources
- YouTube / Vimeo Video
- Links to Web Pages, Portals, Apps
- Events Calendar
- Contacts
- Push Notifications / Alerts
- Forms / Surveys

- Licensed on an annual basis

- £1,000 initial setup fee
- £2,000 - £6,000 per annum



Piota


PUT YOUR LOGO HERE
PYLH App
Powered by Piota
Welcome Chris Elkin
Home
About Us
News
Events
Info
The Team
Feedback
Alerts
Staff
More
Logout
Help
App Analytics
Overview
Visits
Recent
Channels
Growth
Activity
OS
Hardware
Resource
Versions
Units | Today | 1 month | 3 months | All Time
Downloads | 0 | 1 | 4 | 35
Unique visitors | 0 | 1 | 5 | 35
App sections viewed | 0 | 16 | 726 | 13440
For more detail click on the tabs above.
'Today': equates to the last 24 hours.
'All Time': since data tracking started on 14 Sep, 2015.
'Downloads': the number of new downloads in that period.
'Unique visitors': each individual phone or tablet that visits the app during a period is counted as one unique visitor, no matter how many times the same device returns to view the app that day.
'App sections viewed': number of times a section of the app (News; Events calendar; Messages, Information section etc) is opened. If a visitor reads say five News articles it is counted as one section view.
Analytics data was last updated on Tuesday 29th of September 2020 11:23 pm. It is typically updated every 24 hours.
Piota staff: On this module, only the first five tabs are visible to users. The other tabs, as well as this message are only visible to piota staff (in the 'superuser' group).
Our New App
What do you think of it so far?
OK
100%


09:41
Home
NHS
PUT YOUR LOGO HERE
CUSTOM LOGO, COLOURS, TILES AND ICONS
About Us
News
Events
Information
The Team
Feedback
Alerts
Settings
More
Person-Centred Care and Treatment

Piota

Typical App Process

Initial Enquiry
Teams / Google Hangouts — 1hr

Produce Free Trial,
Deliver Initial Training
Submit Proposal — 1hr

Demonstrate Trial App
Staff, Colleagues, Patients etc. — 4hrs

Get Agreement
from organisation.
Raise a PO — 1hr

Project Kick off — 1hr

"The team at Piota were able to produce our COVID-19 Communication App within hours of our initial request. The app has provided us with a quick and easy platform ensuring our Care Home managers and staff are kept up-to date with current local policy and procedural updates, an absolute must in this fast moving, transient world we now find ourselves in. Thanks again Piota for your ongoing support - it has been absolutely fantastic, the responsiveness has been second to none."

Yvonne Higgins
Deputy Chief Nurse, Wolverhampton CCG

Piota

Questions

Piota

Thank you

Chris ELKIN

Head of Healthcare

chris.elkin@piota.co.uk | @chriselkin | 0770 1093733

Slido

Please scan the QR Code on the screen. This will take you through to Slido, where you can interact with us.

The NHS Patient Safety Conference 2022

SCAN ME

8th July 2022- 08:00am – 15:30pm – Mercure Manchester Piccadilly Hotel

Conference hosted by Convenzis Group Limited

UP NEXT...

The NHS Patient Safety Conference 2022:
Breaking a culture of defensiveness

SPEAKING NOW

Darren Sloof

Head of Research and Innovations
Air Purity Ltd

I will be discussing…

"AAirDS (Addenbrookes Air Disinfection Study)"

AAirDS

Addenbrookes Air Disinfection Study

How will this effect
Patient & Staff Safety?

Disclosure

- Air Purity is an independent R&D and Innovations company founded to facilitate the Addenbrookes Air Disinfection Study (AAirDS)
- Darren Sloof is the founder, director and shareholder of Air Purity Ltd.
- Air Purity designed and supplied the air filtration units and air sensors used in this study. Air Purity Ltd had no role in the study design or analysis of the data. Darren Sloof does however collect the data and liaise with other authors over its interpretation.
- Study has both internal and external ethics approvals (South West - Central Bristol Research Ethics Committee)
- Air Purity has no influence on the study and its results, only to facilitate the study. While independent Air Purity acts with
- Study is UKHSA approved and funded

Primary Goals AAirDS

To unequivocally prove if health care acquired infections occur via Aerosol dissemination

Develop monitoring, risk proxies and commissioning standards for interventions

AAirDS

Addenbrooke's Air Disinfection Study

1.Clinical Outcomes
AAirDS-C (clinical)

a) Primary

- i) Incidence of SARS-COV2, adenovirus, HMPNV, Flu A|B, parainfluenza, RSV, picornavirus, norovirus, s.aureus, c.diff, and any Abx Rx c̄ CAP or HAP as indication.
- ii) Incidence of SARS-COV2 alone

b) Secondary

- i) Respiratory viruses excluding SAR-COV2
- ii) C.diff
- iii) S.aureus
- iv) norovirus
- v) HAP - by Abx indication
- vi) All other HAIs
- vii) Severity of C.diff, SARS-COV2 and S.aureus
- viii) Length of stay
- ix) Bed days lost
- x) Abx usage
- xi) Abx cost
- xii) 30 day mortality

2. Feasibility
AAirDS-E (environment)

a) Air sampling weekly

i) Fluidigm **90+ targets**

b) Air sensors

i) PM counts
- 1
- 2.5
- 4
- 10

ii) CO2 levels
iii) RH
iv) Temperature

c) Cleaning

i) Soap usage
ii) PPE usage
iii) Alcohol hand sanitisers usage

d) Validation

i) Standard AGAR/MALDI

3. Acceptability
AAirDS-Q (quantative)

a) Patients survey

b) Staff

i) Survey
ii) Flu/Covid vaccine rates
iii) Sickness

A pragmatic controlled before-and-after study.

AAirDS

Implimentation of air disinfection to prevent hospital-acquired infections in medicine for older people wards.

UK Health Security Agency

UNIVERSITY OF CAMBRIDGE

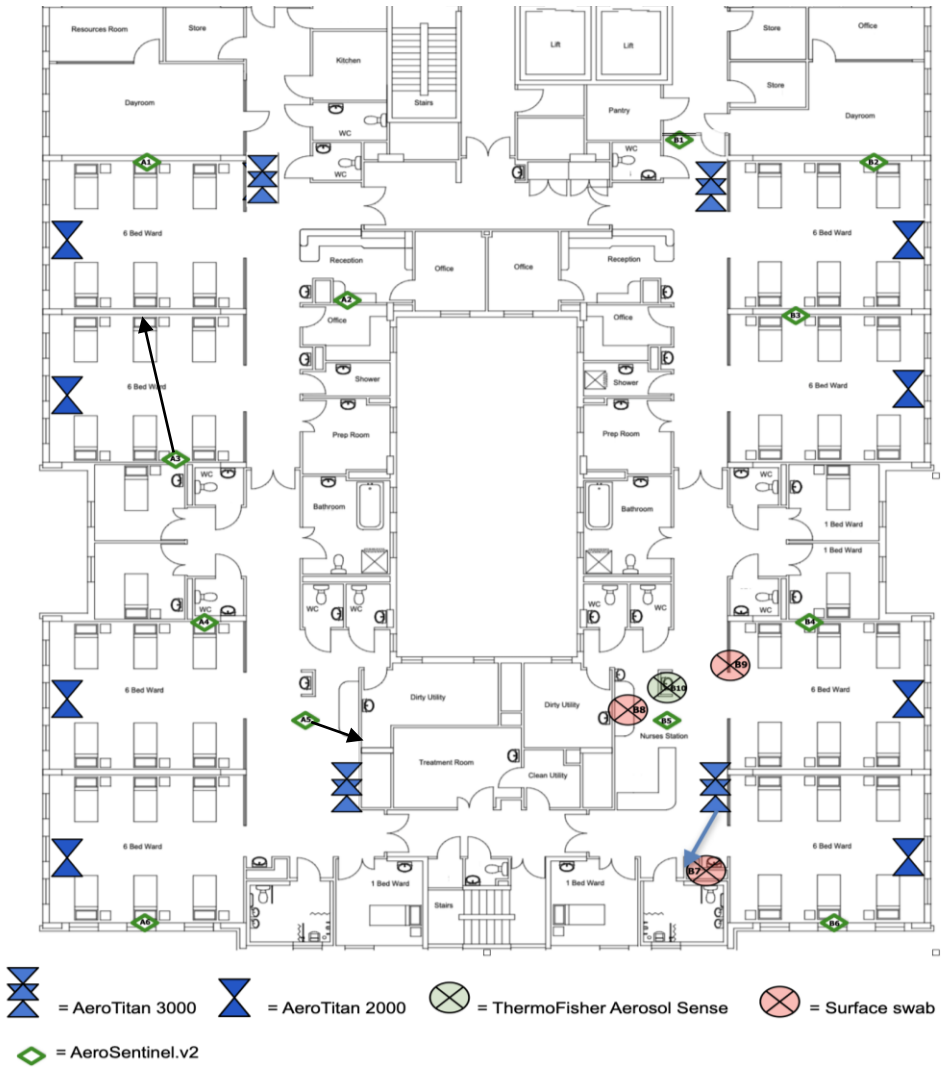
AirPurity

NHS Cambridge University Hospitals NHS Foundation Trust

Unique Features of the Study

- Technology
  - Environmental Sensors to measure and track how Aerosols move (sub 1 micron) and communicate to Air Disinfection Units (worlds first)
  - Air Sampling more than 90 targets from bacteria, pathogens to fungi (worlds first)
  - Air Disinfection units, developed within hospital environments using a new configuration to effect and clean large areas
- Historical records of HCAI's previous 5 years – EPIC system
  - Pre-existing conditions
  - Medication
  - HCAI acquired or externally
- Genome Mapping
  - Patient to Patient
  - Health Care Worker to Patient
- Real world data, no CFD modelling (Computational Fluid Dynamics)

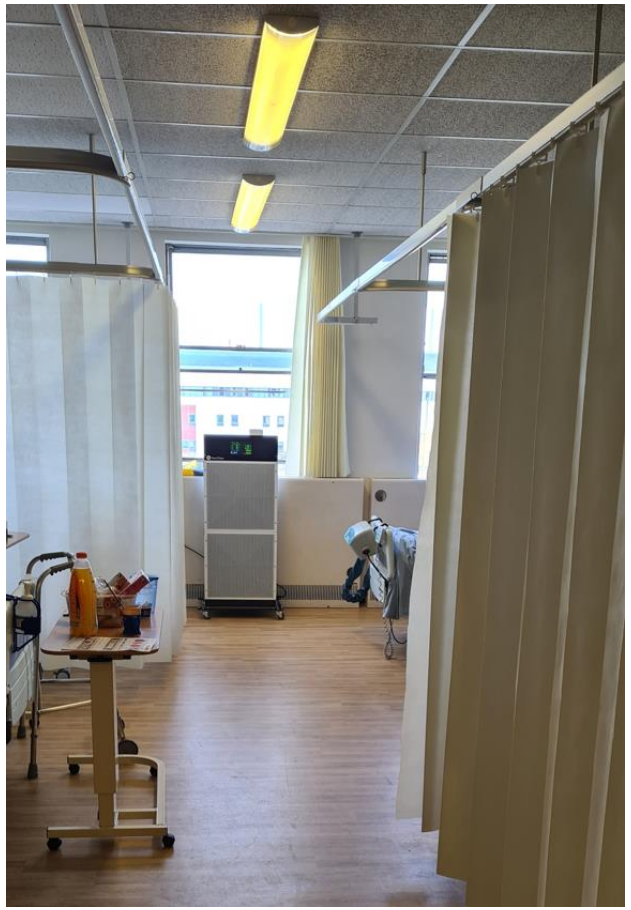
Study Layout



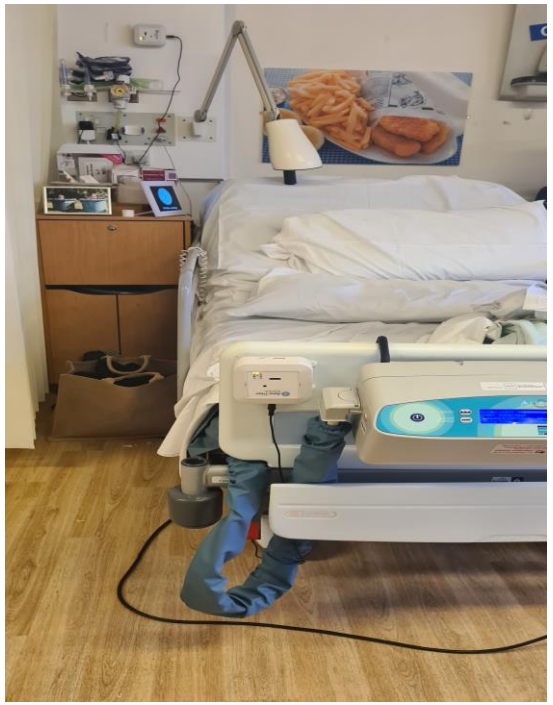
- Study conducted on elderly care wards with poor ventilation for 1 year 3 months (Sept 2021-Feb2023)
- Worst performing wards selected regarding HCAI's
- Mirrored wards, same patient groups and layout
- Control wards with monitoring no interventions

Visual Aids of Technology

Corridors and larger spaces
(AeroTitan 3000)

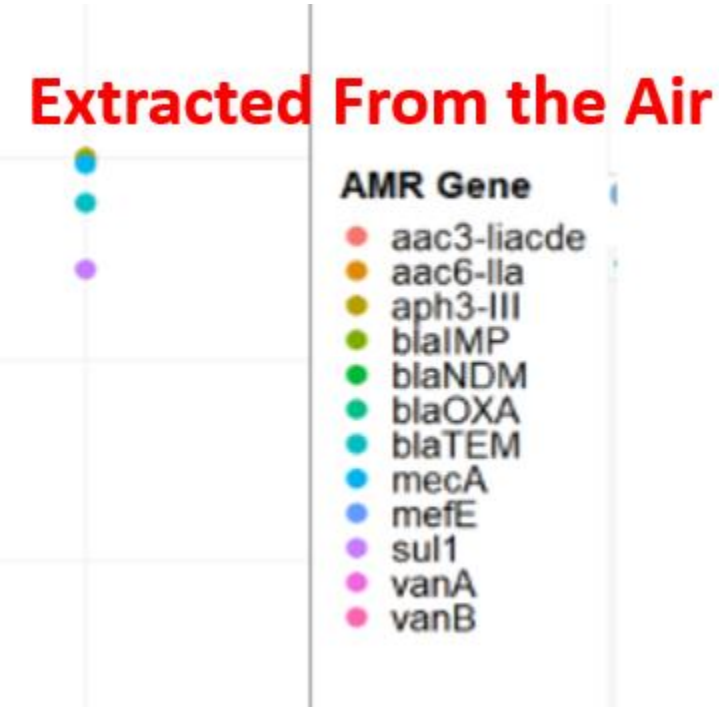


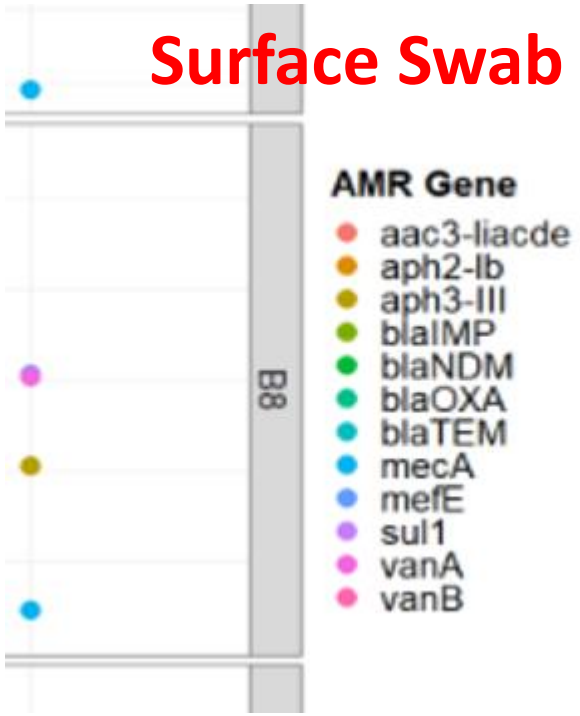
Patient Bays
(AeroTitan 2000)



Environmental sensors
(AeroSentinels)

Clean Surfaces – Prevention should start from the air

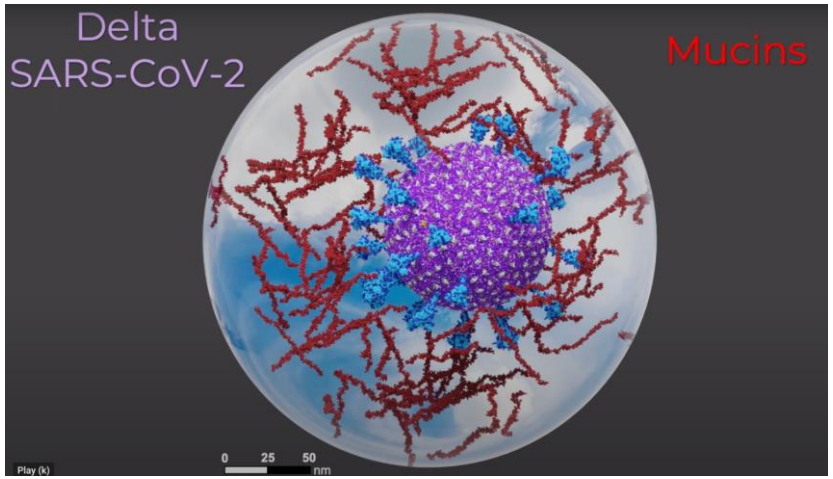




We extract almost the same organisms in the air as on surfaces throughout the ward

Aerosol Movement Video – Patient Fall

- AeroSentinel environmental sensors recorded and tracked how an event occurred and its impact to other patients
- Sub micron aerosol particles recorded illustrated
- Patient falls 3.31am
- Staff arrive immediately after
- Aerosols shown are 1 micron and how they spread through the ward
- Very good example at night as the environment is settled no movements with good ventilation



AAirDS

Addenbrooke's Air Disinfection Study

This study is funded by the UKHSA in partnership with
Cambridge University Hospitals, University of Cambridge and AirPurity UK

NHS
Cambridge University Hospitals
NHS Foundation Trust

UK Health Security Agency

UNIVERSITY OF CAMBRIDGE

AirPurity

Patient Safety Relevance?

- Environments patients occupy spaces that can be hazardous BUT can be just as hazardous to staff

- Poorly maintained environments create sickness this can cause under staffed environments due to health care workers being sick

- If staff sickness reduction is not also prioritised how can the best level of care be achieved with the current high vacancy rate?

Impact of supplementary air filtration on airborne particulate matter in a UK hospital ward

Sloof D1, Butler MB2, Peters C3, Conway Morris A4,5,6, Gouliouris T6, Thaxter R7, Keevil VL2,6, Beggs CB8*

Figures

Figure 1. Layout of the medicine for older people ward showing the positions of the AFU and sensors.

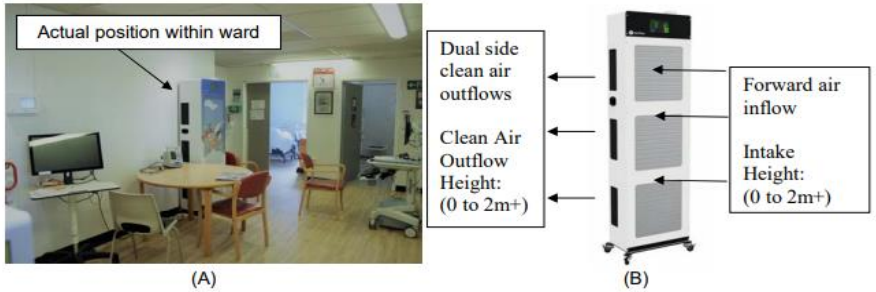


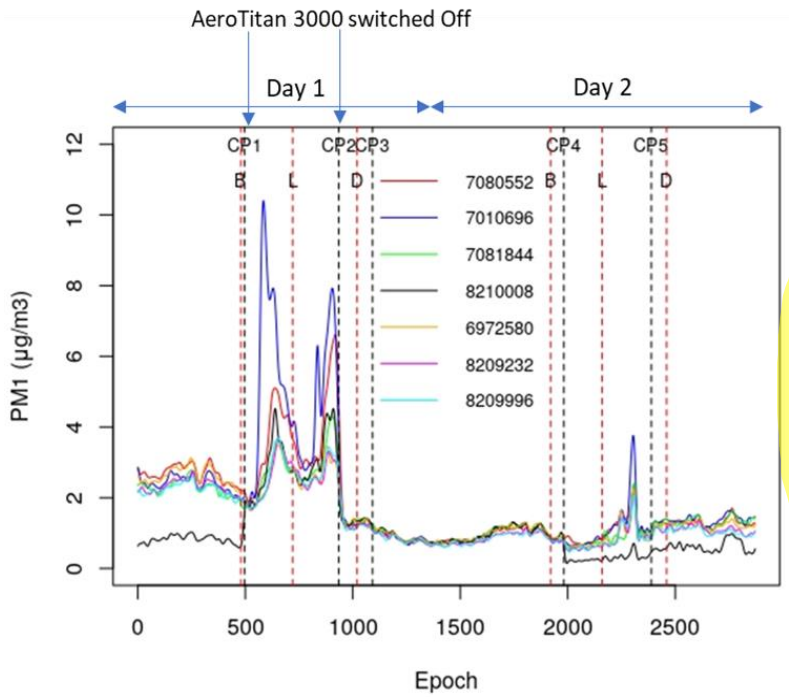
Figure 2. (A) Photograph showing the location of the AFU in the ward, and (B) detail showing the air intakes and outlets of the AFU.

- Natural Experiment when the ADU was switched off for a period of time understanding its effect to the environment

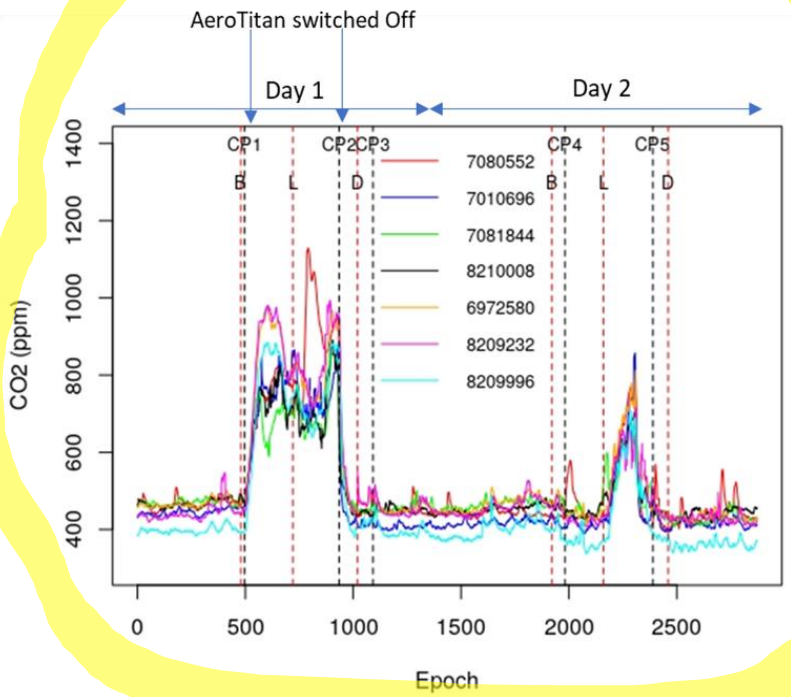
Practical implications

- Aerosols can freely migrate throughout whole wards, suggesting that social distancing measures alone are not enough to prevent SARS-CoV-2 transmission.
- Appropriately sized supplementary room air filtration, if utilised correctly, can greatly reduce aerosol levels throughout ward spaces.
- Air filtration devices are often placed in rooms without any consideration given to their performance. It is therefore important to commission air filtration devices using PM and CO2 sensors before they are utilised in order to demonstrate that they are effective throughout entire ward spaces.

Fine Aerosols (Particulate Matter)



Co2

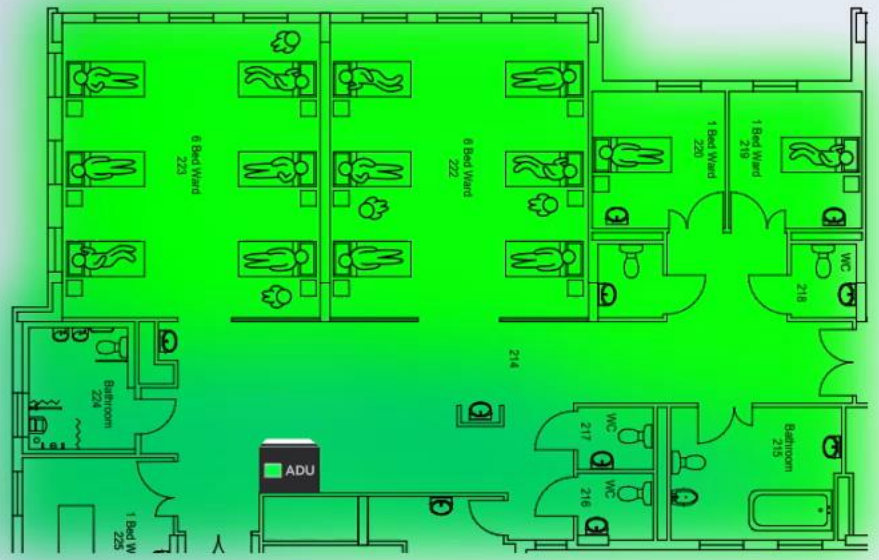


Unexpected finding huge co2 reductions

- Can using the Air disinfection units supplement poorly ventilated spaces through strong clean and recirculation? – Answer Perhaps we need to fully understand the science first!

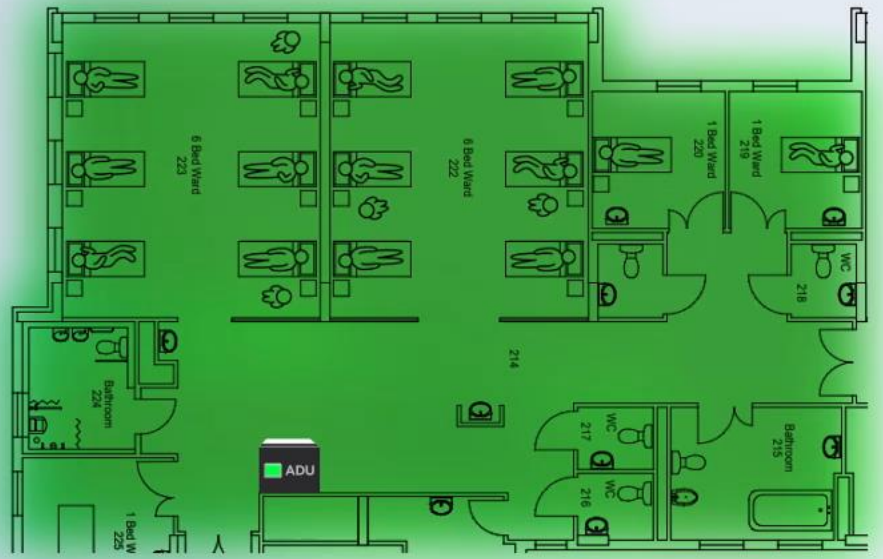
AirPurity

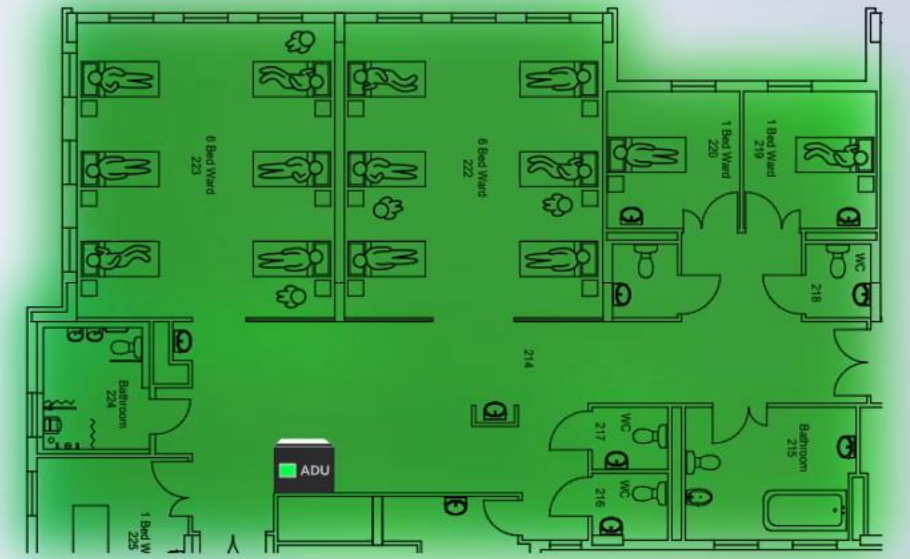
>10 µg/m³
6-10 µg/m³
3-6 µg/m³
<3 µg/m³
ADU off



AirPurity

>10 µg/m³
6-10 µg/m³
3-6 µg/m³
<3 µg/m³
ADU off

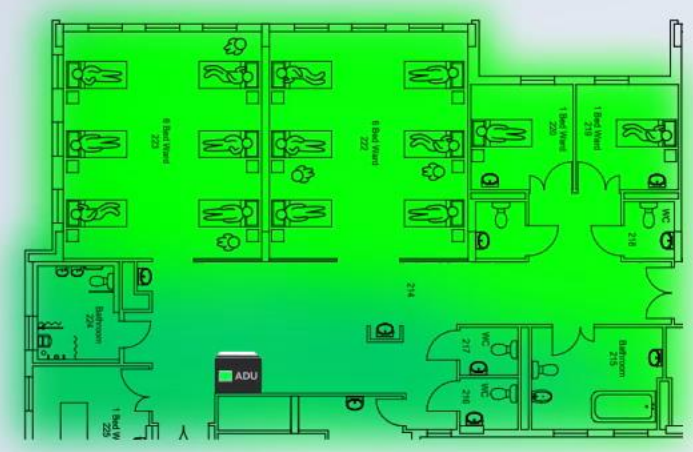


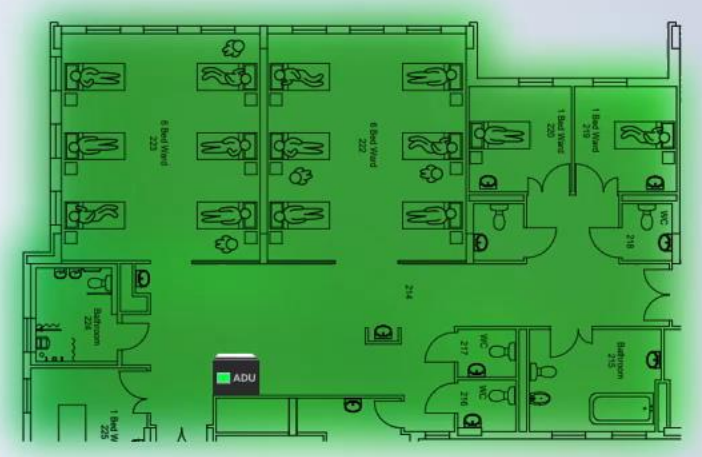


AirPurity

>10 µg/m³
6-10 µg/m³
3-6 µg/m³
<3 µg/m³

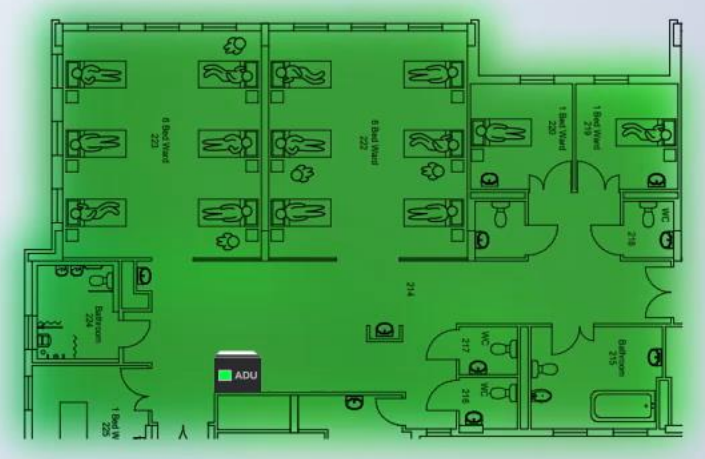
ADU off



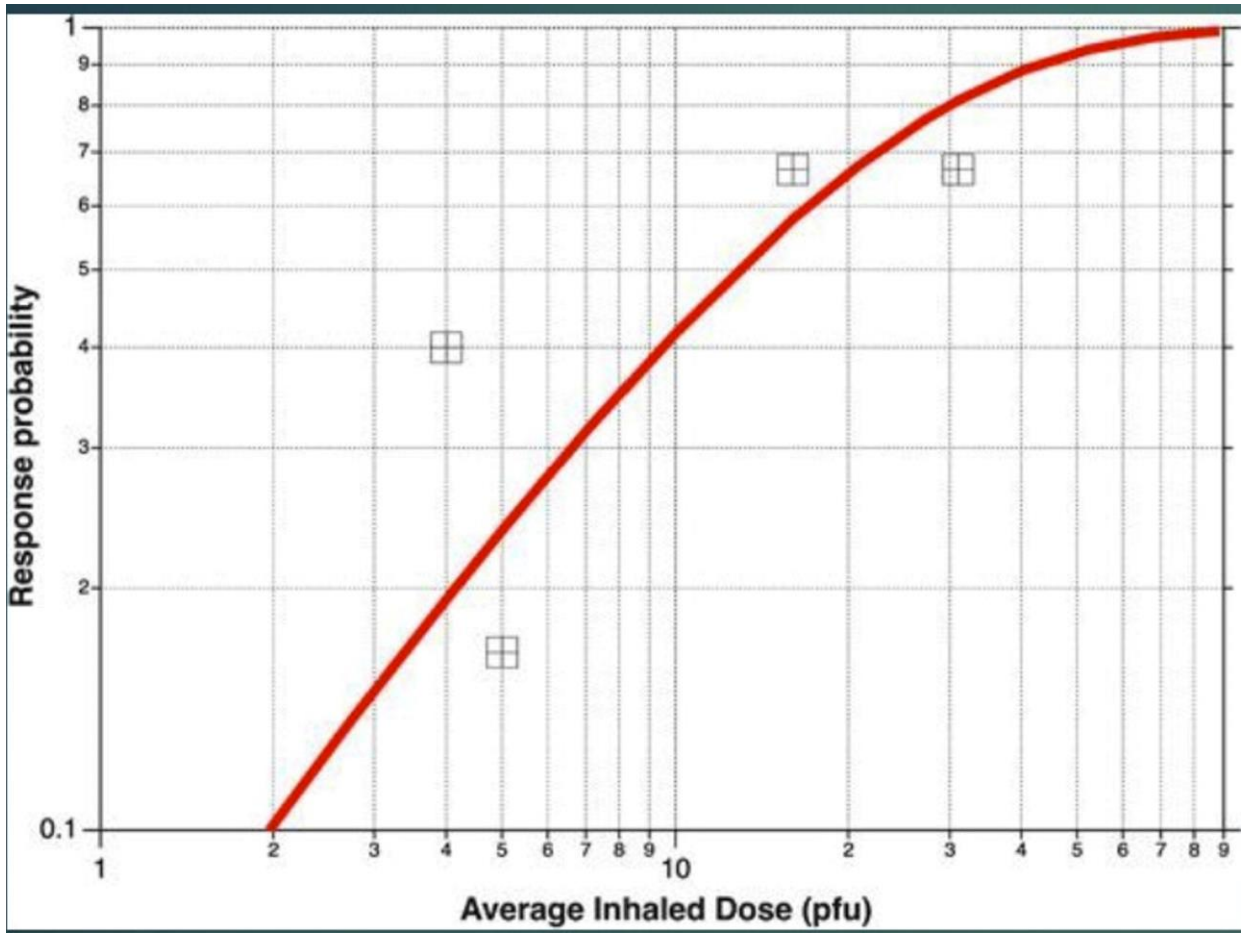


5.30am 7am 9am 11am 1pm 3pm 5pm 7pm 9pm 11pm

6am 8am 10am Midday 2pm 4pm 6pm 8pm 10pm Midnight



Aerosol proxy for HCAI risk?



- High PM1 and below along with co2 (Dose)

(Poor environment volume of Aerosol occupying the space)

- Duration of stay
- Where you stay within a ward
- General bad luck

Action Levels for SARS-CoV-2 in Air: Preliminary Approach https://pubmed.ncbi.nlm.nih.gov/33412806/
SARS-CoV-2: exposure to high external doses as determinants of higher viral loads and of increased risk for COVID-19. A systematic review of the literature

Some key deployment learning

- Off the shelf air disinfection units (Air Purifiers) do not necessarily control an environment and thus could have a very limiting effect possibly none to prevent infections
- Lab testing/certification of units does not necessarily mean applicability in the real world; controlled environment vs chaotic environment where the largest contributor to aerosol production/movement is staff and patients.
- Environmental assessment before and after commissioning is required to show effective implementation
- Plugs, space & noise! Ideal locations rarely exist units should be designed for purpose, noise should be below as an average 55db
- Intervention units should be viewed as semi-portable/permanent

Observations is the Intervention working?

While anecdotal until the study is complete there is noticeable change within the ward using Sars-Cov2 as a proxy

Jan 2021- Aug 2021	Sep 2021- May 2022
4 ward closures full outbreaks	0 ward closures 1 partial bay outbreak probable HCW to Pt
WT, Alpha, Delta	Omicron (more transmissible)

*final study report/publication due May 2023

- Worst performing ward to possibly the best within the trust regarding Sars-Cov2 transmission
- Secondary Sars-Cov2 transmissions thus far appear lower*
- No more odours within the ward
- Staff feedback positive with noticeable changes to ward environment and moral
- HCW to HCW is the biggest challenge, staff rooms can create significant risk of transmission then via close transmission to PT

Final thoughts

- IPC will remain a multifaceted approach –FFP3 or equivalent is still the safest tool for both Patient and Staff as filtration is less effective at short range airborne transmission i.e. <2m.

- No intervention can eliminate infection risk but there will be more measures in the future to aid this from AAirDS.

Please follow AAirDS

Any Questions Please contact Darren Sloof directly on

M: 07712116467

E: darrensloof@airpurityuk.com

AirPurity AeroTitan™ AeroSentinel AeroBullet

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The NHS Patient Safety Conference 2022

SCAN ME

8th July 2022- 08:00am – 15:30pm – Mercure Manchester Piccadilly Hotel

Conference hosted by Convenzis Group Limited

The NHS Patient Safety Conference 2022:
Breaking a culture of defensiveness

SPEAKING NOW

Daniel Hodgkiss

Patient Safety Assistant Programme Manager / Managing Deterioration National Co-Lead at West Midlands Academic Health Science Network

I will be discussing…

"Utilising a systems approach to deliver the Patient Safety Improvement Programmes"

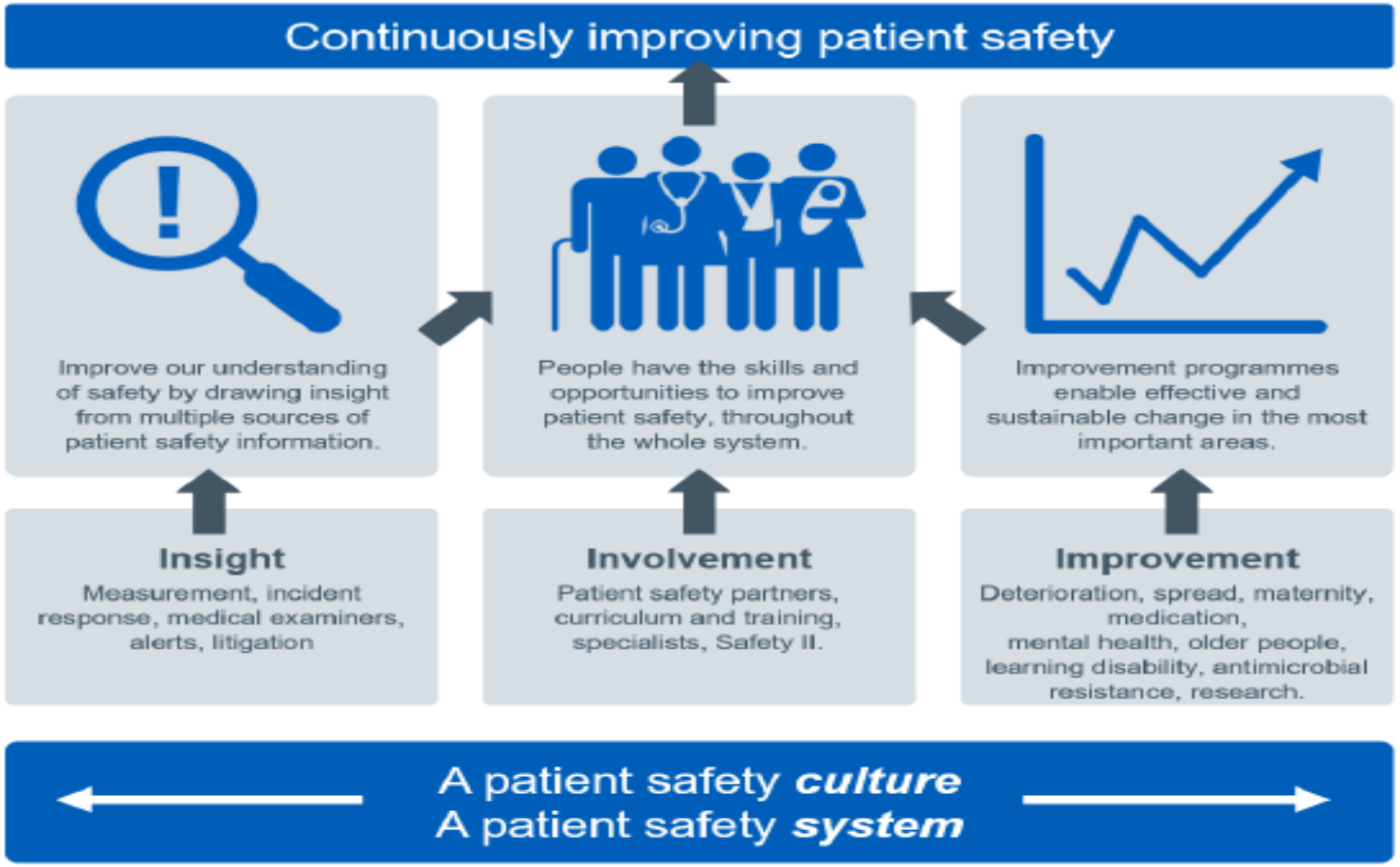
Utilising a systems approach to deliver the National Patient Safety Programmes

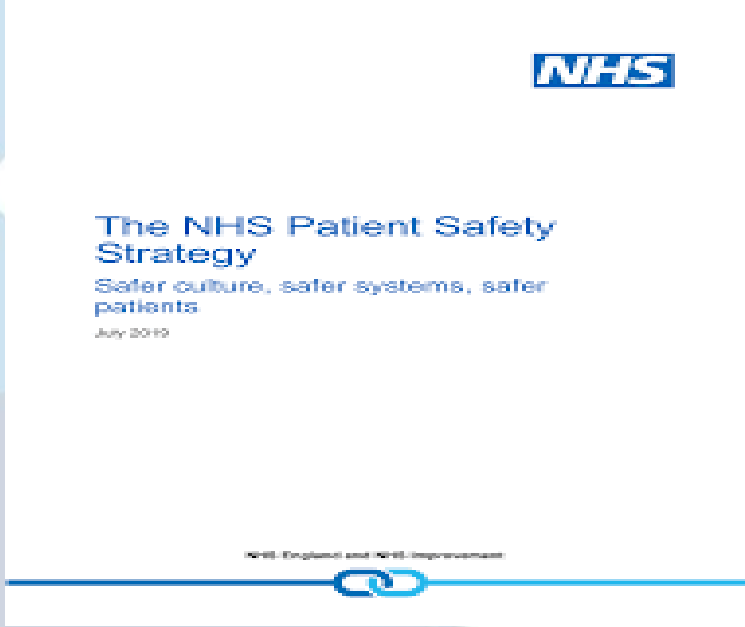
Daniel Hodgkiss
Assistant Programme Manager WMAHSN/
Managing Deterioration National Programme
Associate

@hodgkissmtlc @wmptsafety @wmahsn

“People need to know that the act of keeping patients safe is about having a constantly enquiring mind….

Patient Safety Strategy – NHS Improvement (2019)





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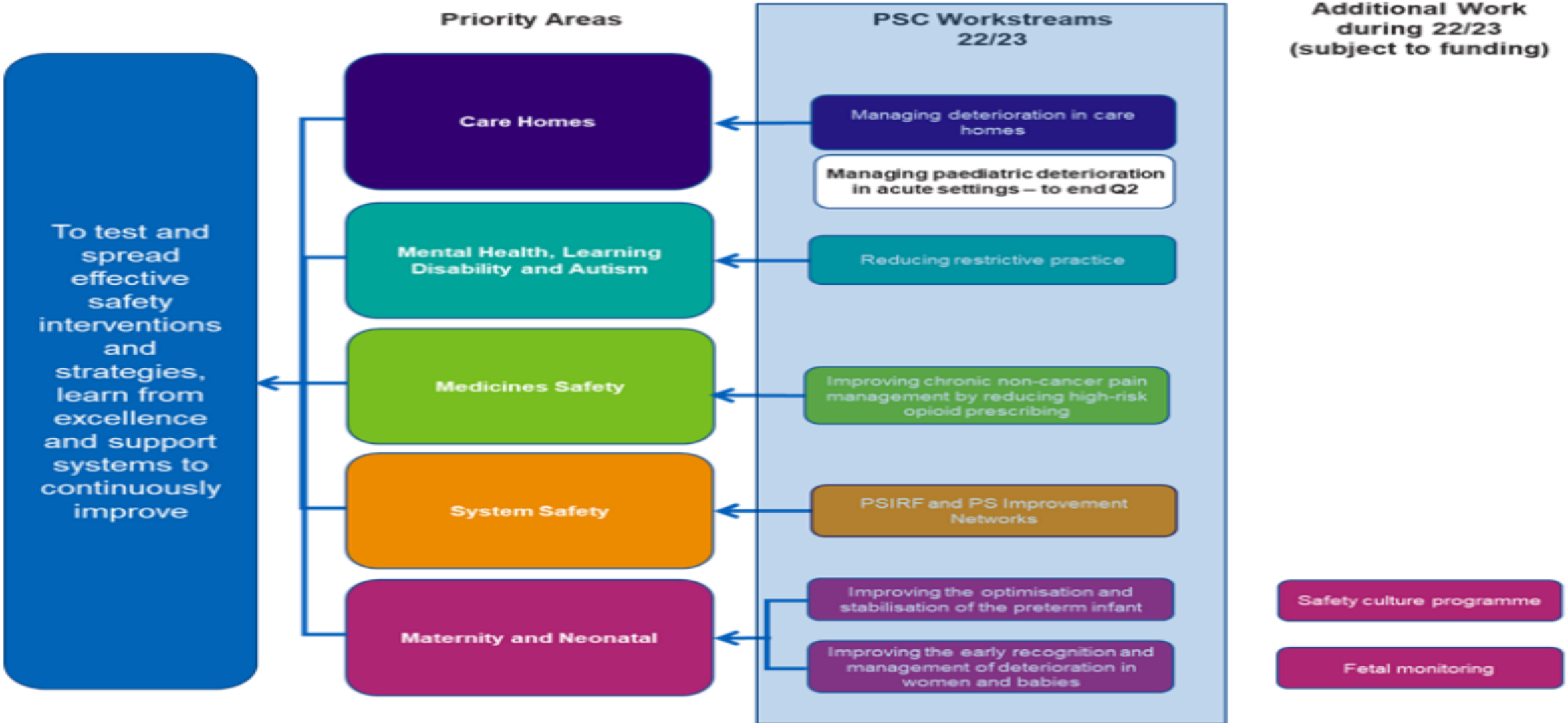
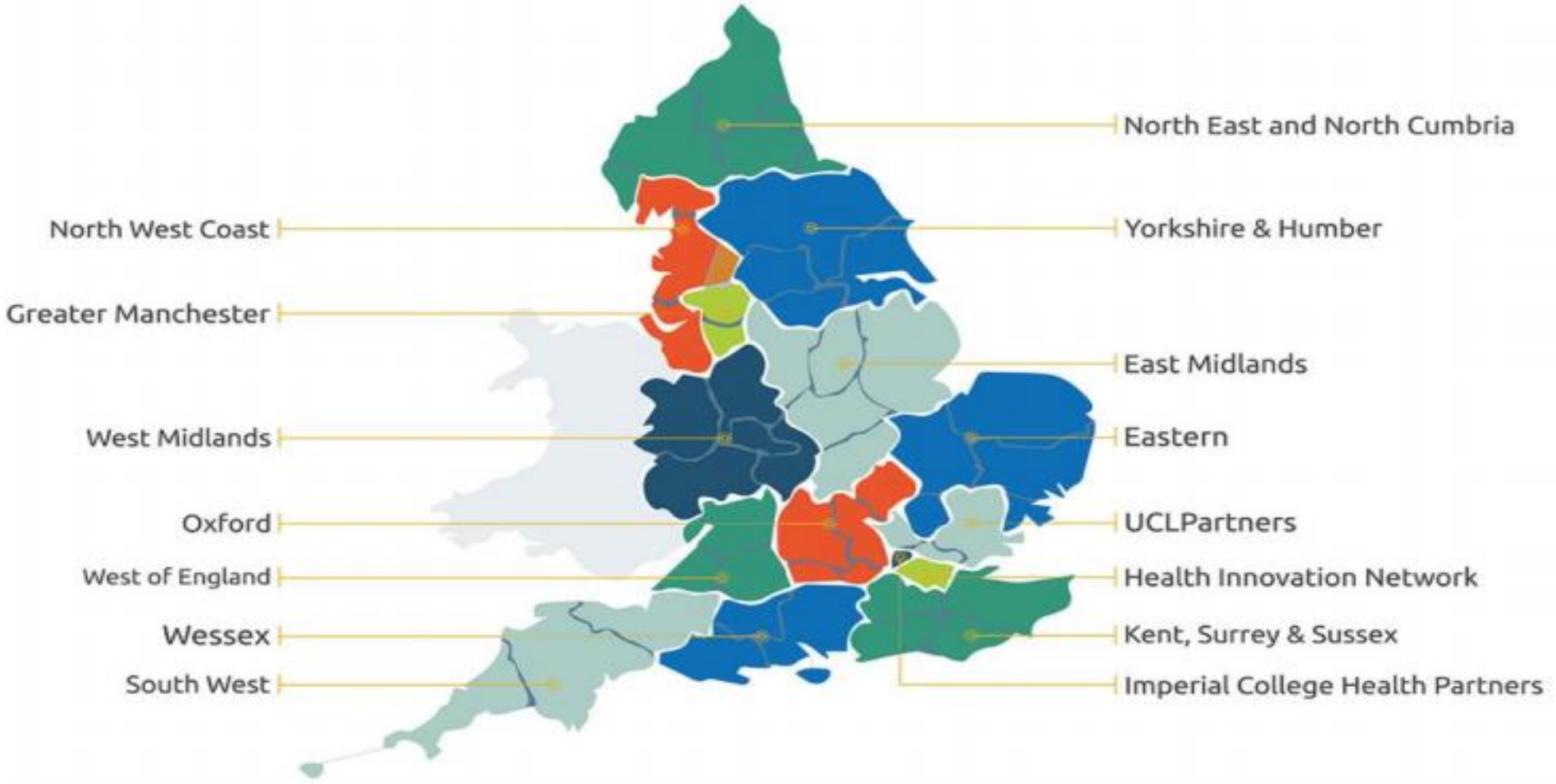
National Patient Safety Programmes 2022/23



Patient Safety Collaboratives (PSCs)



Contact the AHSN Network | The AHSN Network

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Patient Safety Collaborative - a joint initiative

- National funding and coordination by NHS Improvement
- x15 regional PSCs delivered locally by x15 AHSNs
- Systematic approach to quality improvement
- Primary focus on clinical safety, culture, leadership and measurement
- Mechanism for spread and adoption of improvement and innovation
- Local engagement across all care settings
- Build local and regional quality improvement capability
- Harness talents - staff, patients, academia and industry

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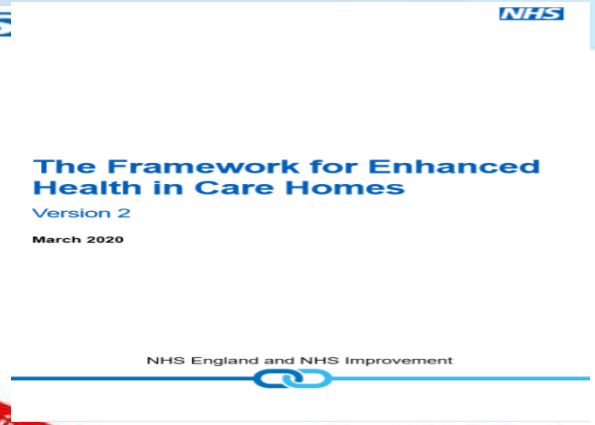
Working in crowded complex space



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Why do we make nuggets of green far too often?

https://www.youtube.com/watch?v=TkZFuKHXa7w

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Utilising a systems approach to safety improvement

"Systems thinking is a discipline for seeing wholes rather than parts, for seeing patterns of change rather than the static snapshots, and for understanding the subtle interconnectedness that gives living systems their unique character"

Peter Senge – The Fifth Discipline (1990)

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Focus on what works

Generate conversation

Learn and **share**

Key enablers for system safety

- Patient and families co-design
- Addressing inequalities
- Safety culture
- Capability & capacity for improvement
- Measurement for improvement
- Patient Safety Networks
- Clinical leadership

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Patient Safety Networks

- Developing regional ‘Patient Safety Networks’ within each ICS feeding into NHS geographical area.
- Pathway wide approaches across the whole system – Multi stakeholder, multi setting

Economies of scale and efficiencies

Mechanism for developing partnerships across multiple organisations

Wider pool of learning for promotion of best practice

Opportunities to remove obstacles at system interfaces due to organisational barriers

Increased capacity to address common issues

System thinking and standard approaches

Local ownership

Shared sense of purpose and direction

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ACADEMIC HEALTH SCIENCE NETWORK

Creating a culture for improvement

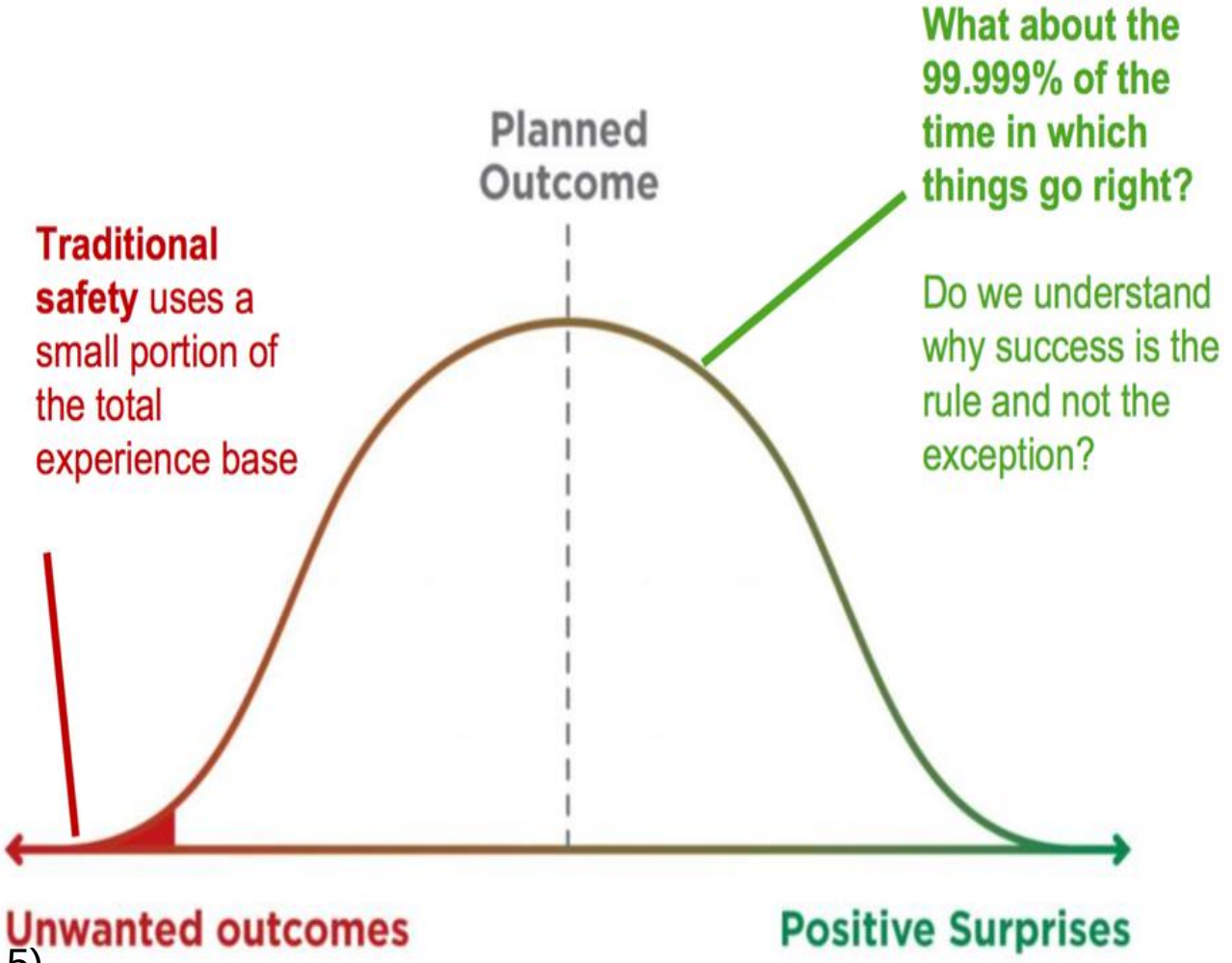
Safety I

Condition where the number of adverse outcomes is as low as possible

&

Safety II

Condition where as much as possible goes right



From Safety-I to Safety-II: A White Paper,Hollnagel et al, (2015)

How do we do this?

Understand the system to know what goes on ‘inside it’

Consider the dynamic properties of healthcare and the way in which it is constantly changing and its unpredictability

Study how people are able to succeed within complex adaptive systems and constantly changing dynamics

Study the mundane, the ordinary and make visible the invisible – ‘work as done’ rather than ‘work as imagined’

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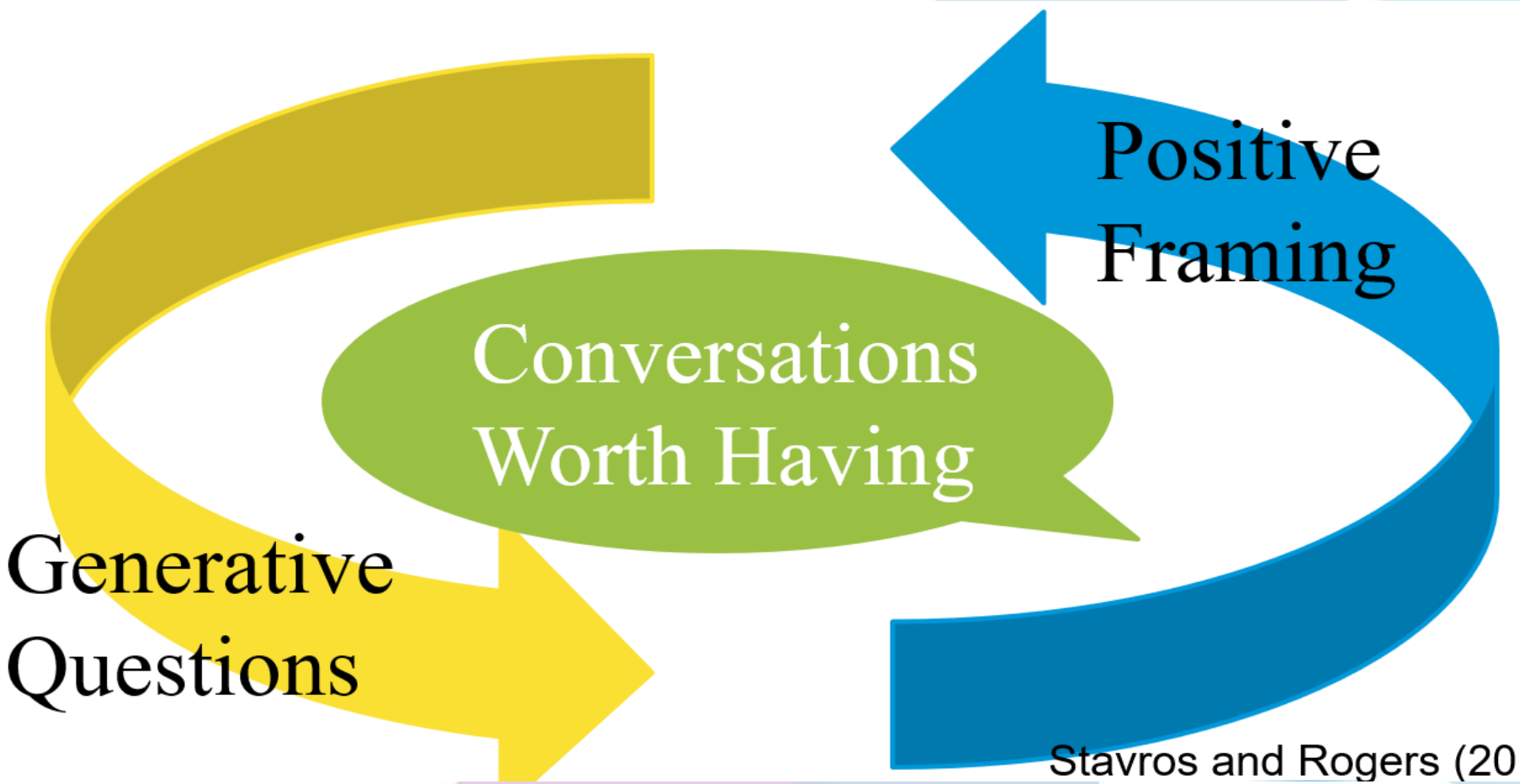
Woodward, S (2020)

Conversations Worth Having



Stavros and Rogers (2018)

west midlands
ACADEMIC HEALTH SCIENCE NETWORK

Use improvement approaches to create a common language

Safety I and Safety II

Human Factors

Psychological safety

Just culture

Appreciative Inquiry

Learning from Excellence

Compassionate leadership

Quality Improvement

west midlands
ACADEMIC HEALTH SCIENCE NETWORK

Use improvement approaches to create a common language

west midlands
ACADEMIC HEALTH SCIENCE NETWORK

“Safety Differently creates the increasingly elaborate and solid basis for empowering and enabling critical and innovative thinking from the bottom up…It asks how things should be done by the people who do them every day”

I am not a policy wonk - Dekker, (2018)

The NHS Patient Safety Conference 2022:
Breaking a culture of defensiveness

SPEAKING NOW

Sharon Rindsland

Manual Handling Senior Co-Ordinator at East Kent University Foundation NHS Trust

I will be discussing…

"Moving & Handling & Patient Safety Analysis – How to Eliminate blame & Ensure Compliance"

Manual Handling injuries who's to blame?

Sharon Rindsland

Senior Manual Handling Co-Ordinator

National Back Exchange Conference Director

East Kent Hospitals University NHS
NHS Foundation Trust

HSE
Role of the Manual Handler

- Recognising risks within manual handling
- Commitment to reduce that risk
- Providing equipment (ensuring its maintained)(LOLER)
- Monitoring compliance
- Commitment to supporting people who have been injured in connection with their work
- Appropriate training (Provide training about the risks from manual handling and how to avoid them) (HSE 2021)

We care

There is more to the Manual Handler than just Training

Working with

- Incident panels
- Tissue viability teams
- Falls teams
- Infection control
- Procurement
- Electrical Medical Engineering (EME)

Case study

- Patients are prone to developing pressure ulcers during their stay in hospital.

BUT WHY?

- The nurses move patients regularly
- They have completed their training so they know how to use the equipment?

What's going wrong?

‘Its only skin
So why are we worried?

East Kent Hospitals University NHS
NHS Foundation Trust

Looking at hospital acquired pressure ulcers

CAUSES OF PRESSURE ULCERS

Extrinsic
- Pressure
- Shear
- Friction

Intrinsic
- Health status
- Mobility
- Posture
- Sensory impairment
- Infection Nutrition
- Status body weight
- Previous pressure damage

We care

PRESSURE ULCERATION FROM SHEARING

Shearing.

- This is where pushing or pulling the skin means more than one layer of skin slides against each other. This can cause damage to these layers or they may become detached from each other all together.

PRESSURE ULCERATION FRICTION

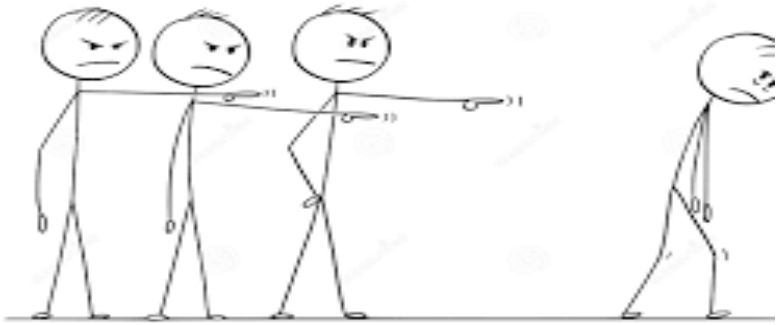
Friction.

- This is where two surfaces rub together, so this could be the skin and bed sheets, or a chair cushion, etc., or poorly fitting clothing or manual handling aids. Hot, moist skin is likely to experience even more damage from friction than more healthy skin.

- POOR MANUAL HANDLING TECHNIQUES CAN RESULT IN PATIENTS EXPERIENCING ALL OF THESE FORMS OF PRESSURE AREA DAMAGE.

Who's to blame if we don't use the equipment provided ?

- Is it the Nurse/Carer?
- Is it the Trust



Instead if blame, in our trust we looked at the human factors of why they were not using the equipment, in this case slide sheet.

Incident review panel

- Look at what happened
- What equipment was available
- How many staff
- Training
- Risk assessment
- Patient assessment

The incident panel take the incident down to the bare bone to understand how and why

Findings

Investigation Tool,

INVESTIGATION TOOL

NHS East Kent Hospitals University NHS Foundation Trust

Ward Manager/authorised staff member to complete for all Category 2, 3, 4, DTI and Unstageable Hospital acquired Pressure Ulcers.
Consider Adult Safeguarding review for Category 3, 4, unstageable or multiple Category 2
Attach completed copy to the Datix Incident report and notify the Tissue Viability Team.

PATIENT NAME:	
DATE OF BIRTH:	**NHS NO:**
DATIX WEB: WEB214700	

CATEGORY OF INCIDENT	
BODY LOCATION: Buttock	
INVESTIGATOR:	

	ALL APPROPRIATE INTERVENTIONS IN PLACE	CLINICAL JUDGEMENT REQUIRED	FURTHER INVESTIGATION and ACTION REQUIRED	Comments: (use for any additional information/supporting evidence)
Datix Was a Datix completed when pressure damage first noted i.e Category 1 or on deterioration?	**Yes, Datix completed on detection of Category 1 AND on deterioration of existing damage?** √	Datix only completed when pressure ulcer deteriorated ☐	No Datix completed at all ☐	**Admitted on 3rd April. Highlighted to FK on 5.4.22 and Datix completed by ward also. Some evidence of purple discolouration at this point.**
Risk Assessment Was patient risk assessed?	**Within 6 hours of admission** √ **(patient in for less than 6 hours)**	Within 24 hours of admission ☐	Over 24 hours/Not risk assessed ☐	**Risk assessed within 25 minutes. Admitted to the ward at 04.25 on 5/4/22 and RA completed at 04.50**
Was patient's risk reassessed?	**Daily/Weekly/on change of condition** √	Infrequent ☐	Not reassessed ☐	**Evidence of daily risk assessment. Sometimes classed as moderate risk but would have always been high**

HUMAN FACTORS

OUT OF SITE OUT OF MIND

- If slide sheets are not by the patients bed, staff will not go and find them.
- Its quicker to pull on the bed sheet
- It takes time to remove PPE to go and get slide sheets
- We have been using bed sheets for years

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NHS Foundation Trust

Working together regular Audits of Equipment and training

- Manual Handling put business case together to ensure slide sheets are behind each bed
- Manual Handling Audit slide sheet use on each ward monthly

January /February comparison	January	February	Slide Sheets in store room
K&C BRABOURNE WARD	100.0%	←100.0%	100.0%
K&C CLARKE WARD	83.3%	↓79.4%	100.0%
K&C HARBLEDOWN WARD	70.8%	↑79.2%	100.0%
K&C INVICTA WARD	100.0%	←100.0%	100.0%
K&C ITU	100.0%	←100.0%	100.0%
K&C KENT WARD	83.9%	↑93.3%	100.0%
K&C KINGSTON WARD	69.2%	↑88.5%	100.0%
K&C MARLOWE WARD	76.8%	↑85.7%	100.0%
K&C MOUNT MCMASTER	88.8%	↑90.0%	100.0%
K&C EAST KENT NEURO REHAB	78.9%	↑88.2%	47.1%
K&C ST LAWRENCE WARD	87.5%	←87.5%	100.0%
K&C MEDICAL DAY UNIT	100. 0%	←100.0%	100.0%

We care

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NHS Foundation Trust

Tissue viability pressure ulcer dashboard, identifying gaps with equipment and training

Subcategory	October 2021	November 2021	December 2021	January 2022	February 2022	March 2022	Total
Hospital acquired cat 1 pressure ulcer	9	8	4	4	5	4	34
Hospital acquired cat 2 pressure ulcer	16	20	15	14	13	18	96
Hospital acquired cat 3 pressure ulcer	1			1	1		3
Hospital acquired deep tissue injury	4	5	3	3	5	5	25
Hospital acquired Moisture Associated Skin Damage	23	21	21	19	18	6	108
Hospital acquired unstageable pressure ulcer	2	4	8	6	4	4	28
Medical device related hospital acquired deep tissue injury		1	1	1	2	1	6
Medical device related hospital acquired pressure ulcer cat 1	4	1	3	1			9
Medical device related hospital acquired pressure ulcer cat 2	3	2	5	6	2		18
Medical device related hospital acquired pressure ulcer cat 3	1						1
Medical device related hospital acquired unstageable pressure ulcer	3		1			1	5
Total	66	62	61	55	50	39	333

We care

Trust Challenges

- Covid-19
- Increased patient acuity and length of stay/aging population
- Decreased resource for community care
- Staffing issues
- Funding for equipment/lengthy processes
- Meeting targets

East Kent Hospitals University NHS
NHS Foundation Trust

Expectations from Industry

- Behaviours

" I'm good or bad depending on the circumstances, the situation, and the people involved. "

We care

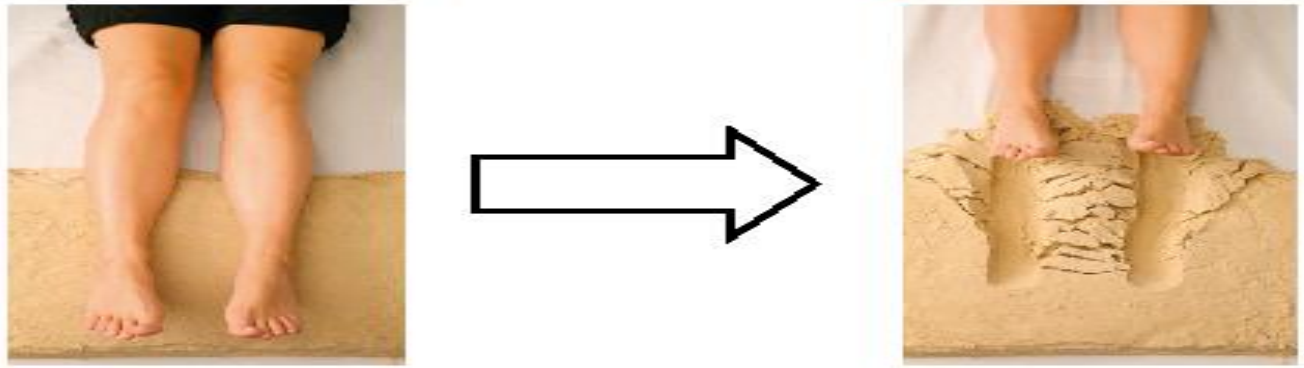
Expectations from Industry with manual handling and tissue Viability combined

- Support with:
- Training and Education
- Piloting of equipment
- Resources i.e printed pathways
- Case studies and product evidence
- Ongoing support

NHS
East Kent
Hospitals University
NHS Foundation Trust
Manual Handling

Slide Sheets Stop Shearing!

When a patient is repositioned in bed using a high friction material (i.e. Bed sheet), the risk of shearing to patients' skin is high! :



When a patient is repositioned in bed using 2 slide sheets, the risk of shearing to patients' skin is much lower! :

Always use 2 slide sheets if the patient is unable to reposition themselves independently.

For training on Slide Sheets, please contact your Department Manual Handling Link Assessor or the Manual Handling Team via email: ekh.tr.manualhandling@nhs.net

We care

WORKING WITH OUR SPECIALIST TEAMS

- We Reduced hospital acquired pressure ulcer

		2018			2019
sacrum/Buttock		86			53
Back		3			1
calf		1			2
ears		3			1
Elbows		3			5
foot		7			5
heel		27			11
hips		1			1
knees		2			0
shoulders		2			0
spine		1			0
thighs		6			0
toes		2			0

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NHS Foundation Trust

Keep Our patients moving by working together

We care

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NHS Foundation Trust

Any Questions

We care

The NHS Patient Safety Conference 2022: Breaking a culture of defensiveness

Q&A PANEL

Chris Elkin

Head of Healthcare
Piota Healthcare Apps

Darren Sloof

Head of Research &
Innovations – Air Purity Ltd

Daniel Hodgkiss

Patient Safety Assistant
Programme Manager

Sharon Rindsland

Manual Handling Senior
Co-Ordinator

The NHS Patient Safety Conference 2022:
Breaking a culture of defensiveness

Chair Afternoon Address

Jane Walsh

Senior Improvement Advisor
Advancing Quality Alliance
(Aqua)

The NHS Patient Safety Conference 2022:
Breaking a culture of defensiveness

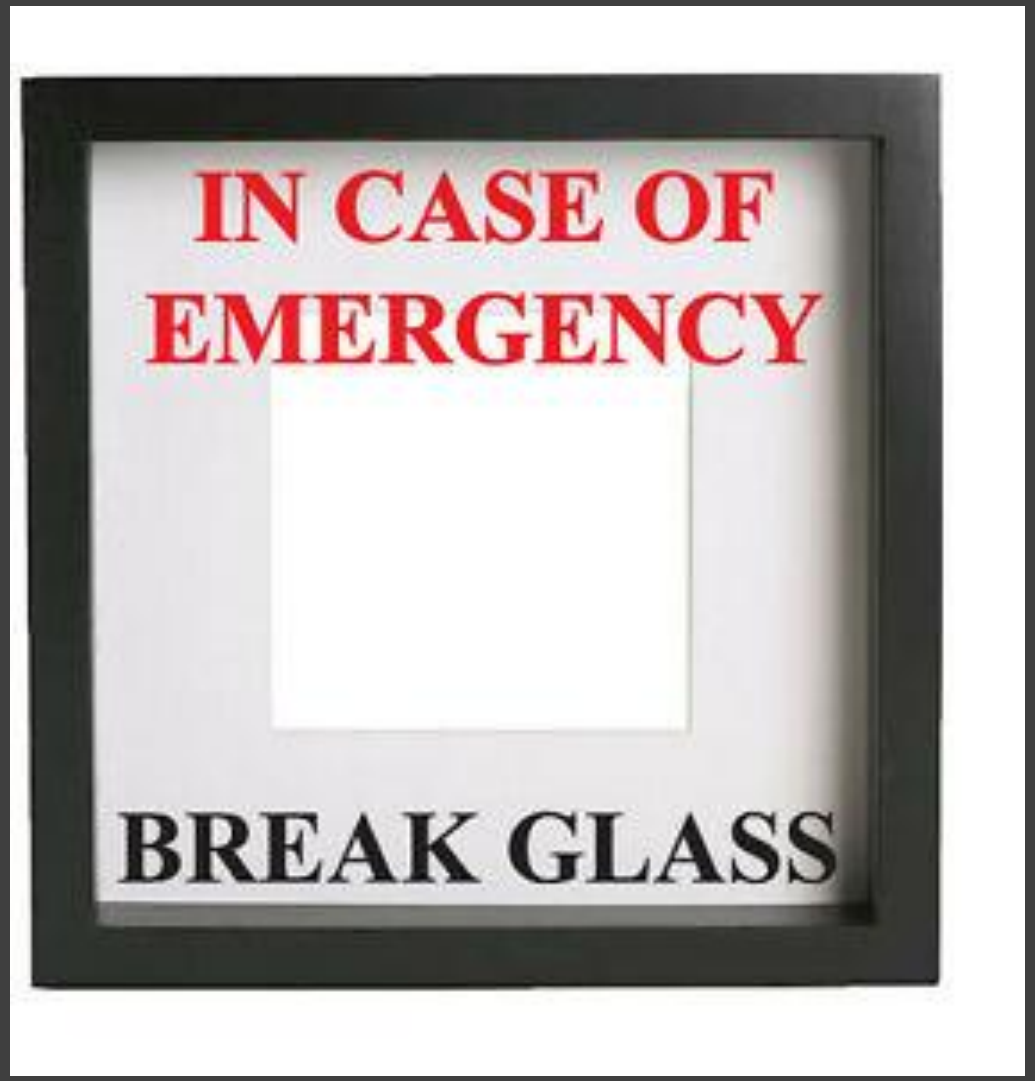
SPEAKING NOW

Angela Hayes

Clinical Nurse Specialist, Specialist Palliative &
Supportive Care at The Christies NHS Foundation Trust

I will be discussing…

"Sustainability and Net Zero in the NHS"



Climate Change: **A Health Emergency!**

Angela Hayes
CNS Palliative/Supportive Care
(Clinical Lead Sustainability)
The Christie Foundation Trust

C02 - a powerful Greenhouse gas

Acts like a warming blanket round earth

- Global Warming
- Climate Change

Serious consequences (health included!)

Green matters, 2020

Causes of Climate Change

Human Activity!

- Burning fossil fuels
- Farming
- Deforestation = 36 football fields/min

Health Care plays a big part!

The Global Impact of HealthCare

NHS produces around 25 million tonnes of carbon/pa

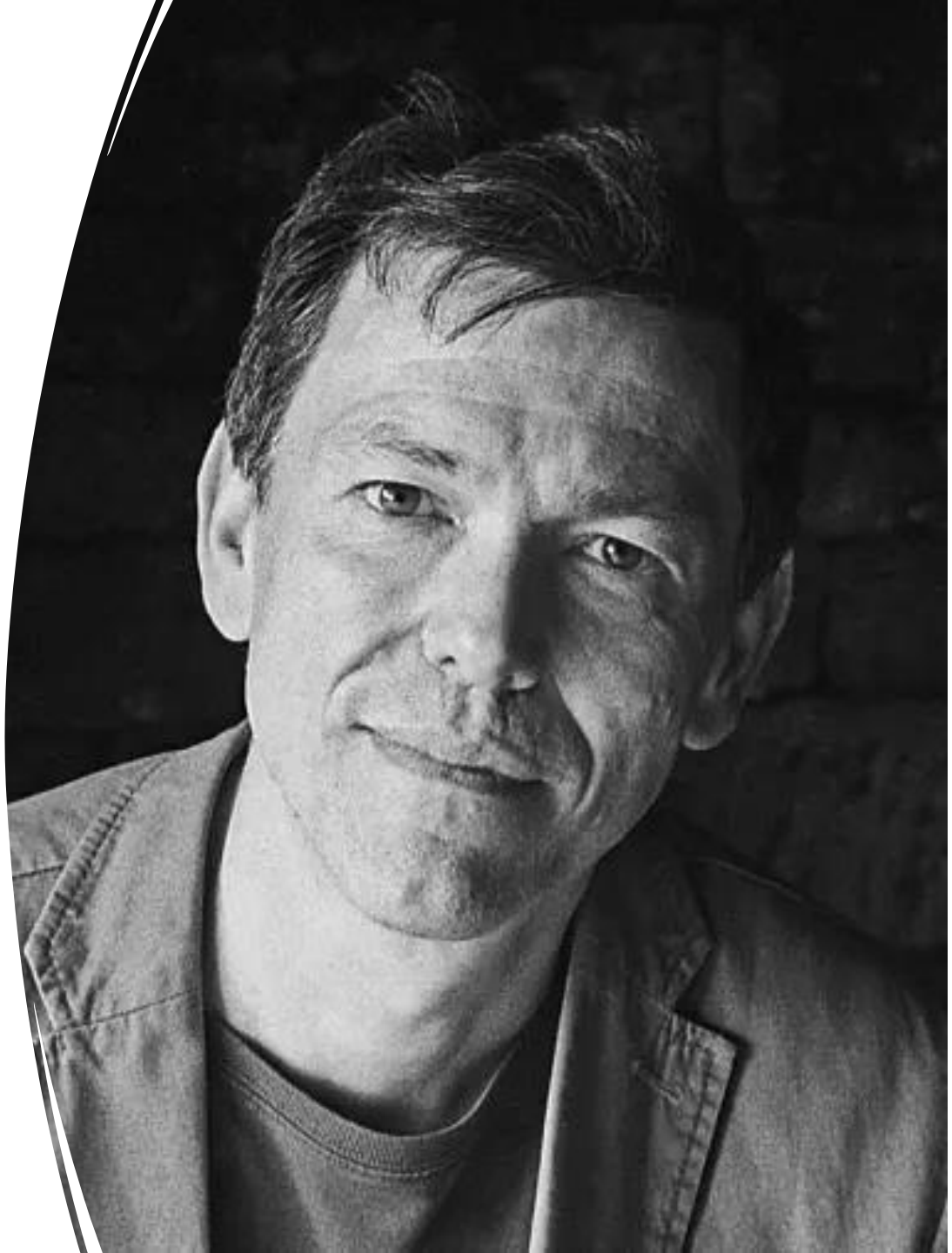
Equivalent to all emissions of Sri Lanka!

(kingsfund.org.uk)

“Climate Change is a Medical Emergency

… and demands an emergency response”

Hugh Montgomery,
Professor of Intensive Care Medicine,
Director, Centre for Human Health & Performance,
University College, London




RC
PSYCH
ROYAL COLLEGE OF
PSYCHIATRISTS


MANCHESTER
1824
The University of Manchester


RCPCH
Royal College of
Paediatrics and Child Health
Leading the way in Children's Health


NHS
The Newcastle upon Tyne Hospitals
NHS Foundation Trust


Royal College
of Nursing
The voice of nursing in the UK


Royal College
of Physicians


UK
Parliament


RC
GP
Royal College of
General Practitioners
70 YEARS OF BEST PRACTICE

Public Health England

Climate Change and ill-health

- Strong links
- Threatens undermine public health gains of last 50yrs!

Climate Change

- Undermines foundations of good health
- Deepens Health Inequalities
- Nurses have duty to protect/improve public health
- Nurses should Demand ‘Stronger Action!

Royal College of Nursing

BMJ Special Climate Change Edition, Editor's Choice, Oct 2021

"A world on the edge of climate disaster"

- Call for action from HCPs & Managers
- Hold to account, those in authority - promote & protect health

Human Cost of Climate Change

Air pollution

Extreme weather & rising sea levels - Floods, Fires, Storms, Droughts

Scarcity of resources – safe water/cultivatable land

Conflict & wars

Displacement of people

Exploitation of vulnerable (shelter? Security? trafficking, slavery)

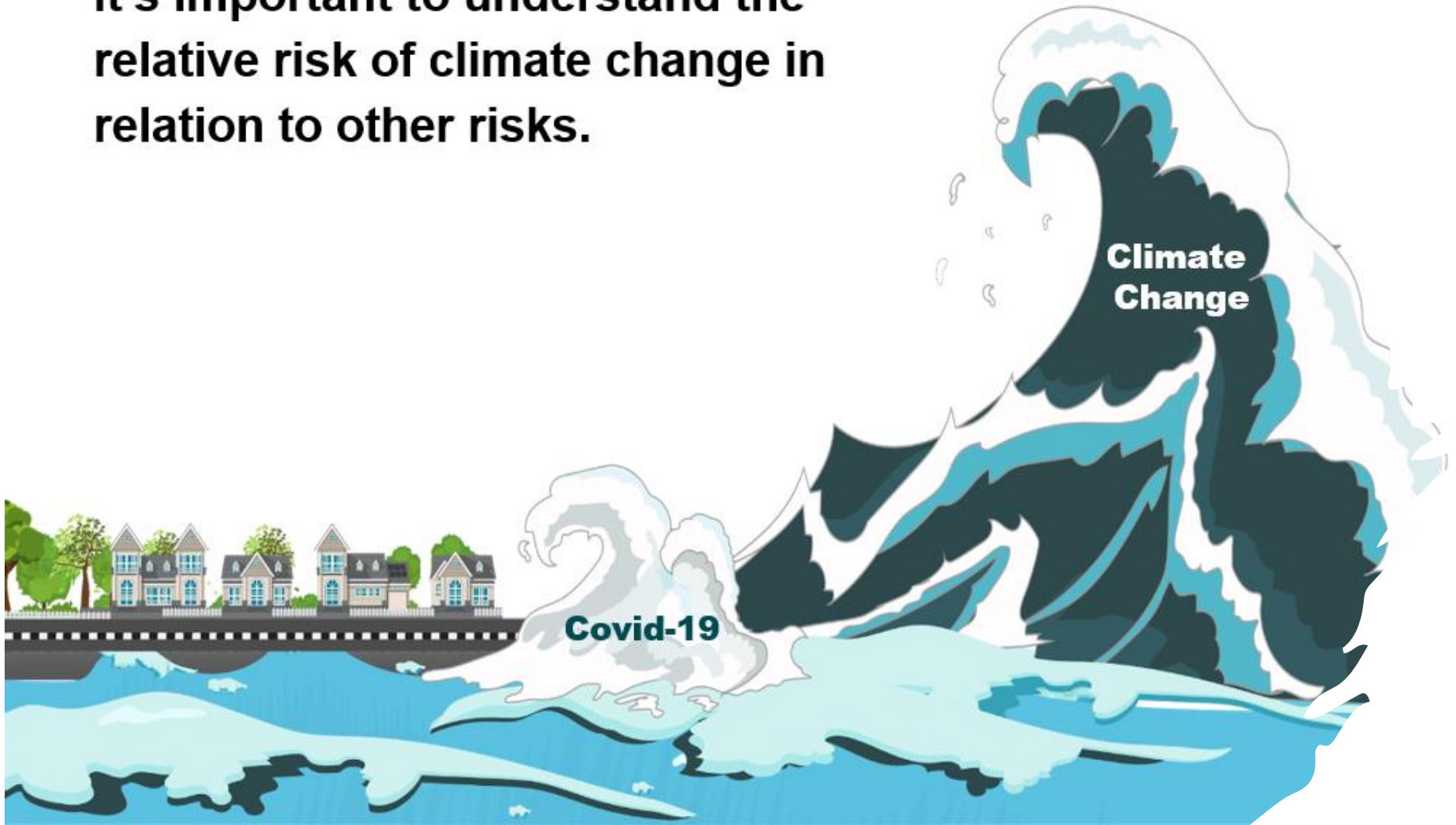
Health Effects of Climate Change

Increased:

- Risks of further pandemics
- Disease (asthma, cancer)
- Heat-related disorders
- Vector/food/water bourne disease
- Respiratory/allergic disorders
- Malnutrition
- Social & Mental health issues

Climate Change and COVID-19

It's important to understand the relative risk of climate change in relation to other risks.



Ella Kissi-Debrah – Aged 9yrs

Ella Kissi-Debrah – Aged 9yrs

Ella – Inquest Findings 2014

‘exacerbated by air pollution/ traffic emissions’

Ella's mother **not given information** "about health risks of air pollution and exacerbation of asthma".

Address pollution.org

Didsbury: Jan 2021

Services at The Christie?

We can’t put off action any longer!

We’re all in the same boat?

Same storm! Some on yachts…

Climate Injustice: Vulnerable are the Most Vulnerable

- Children
- Elderly
- Poor
- Minority Groups
- Those with Chronic disease/disabilities
- Women
- Low income countries

Those from low income countries

usually have the **lowest carbon footprint**. Yet…

- MORE likely to be **affected**
- Far **LESS resilient**

The Facts!

- Over 90% of people breathe unhealthy **levels** of air pollution
- Environmental factors are responsible for around 13 million deaths a year
- Less than 2% of finance goes to fund health projects to tackle climate change

World Health Organisation

With a 2-3 Degree increase in Global temperatures…

- ¾ of Spain faces becoming desert-like
- 99% of land in Cyprus, could turn to dust
- Iberian Peninsula could experience drought for over 7 months/year

The European Court of Auditors, Dec 2018

With a 2-3 Degree increase in Global temperatures…

- ¾ of Spain faces becoming desert-like
- 99% of land in Cyprus could turn to dust
- Iberian Peninsula could experience drought for over 7 months/year

The European Court of Auditors, Dec 2018

Ask the Audience!

Raise your hand if, in your working life, you've ever discussed Climate Change?

The NHS declared…

Climate change is a **Health Emergency**’

How do we act in an Emergency?

ARE WE ACTING LIKE WE'RE FACING AN EMERGENCY

How do we act in an Emergency?

Health Care Professionals

- Have a moral duty to act!
- Protect Human Rights
- Promote Social Justice

To ACT in response to an **EMERGENCY!**

Sustainability on the Agenda!

- Literally!
- **A Priority**

Talk about Sustainability:

- **Managers**
- **Colleagues**
- **Patients**
- **Family**
- **EVERYBODY!**

- **Again & again & again…**

Is there a difference between…

A Metered dose inhaler?

A Dry powder inhaler?

Green inhalers?

Equivalent tailpipe greenhouse gas emissions from a Ventolin Evohaler (containing 100 2-puff doses) and a Ventolin Accuhaler (60 1-puff doses). Assumes car achieves 100gCO2/km.

Cut down Meat & Dairy!

Effective way to reduce carbon footprint (up to 70%)

Health Benefits - reduces

- cardiac disease
- diabetes
- cancer
- strokes
- weight

Saves pounds (& pounds!)

Oxford University 2020

Less car, more exercise!

Less fossil fuels = reduces

- Air pollution
- Road traffic accidents
- Respiratory disease
- Cardiac disease
- Obesity
- Diabetes
- Strokes
- Cancer

- **Increases health!!**

My Green journey

Climate breakdown. Act now!

If not you, who?

If not now, when?

“You’ll be a long time gone & the choices you make, they linger on…”

The Hayes Sisters

[A Note from Greta - starring the Christie's Nursery kids - YouTube]

The Green Ward Competition

Green ideas in your area?

1. Carbon Savings?
2. Cost Savings?
3. Patient benefits?

THOR: A green Hero!

Photobiomodulation Therapy - for Mucositis
https://youtube/mm7liMxgXzg

The NHS is part of problem
but, can be part of
The solution!

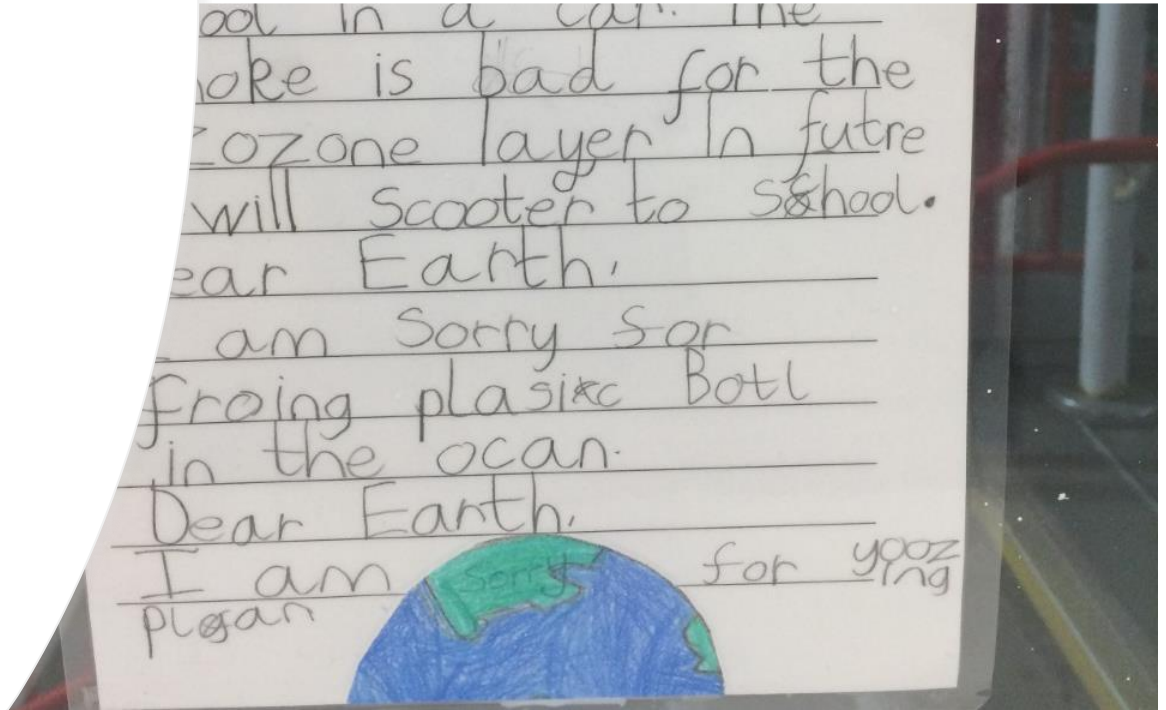
What changes can **you** make?

Ripple effect – I'd urge you to …

- DOT!
- Green ward ideas?
- Speak about Climate Change!

Their Future in Our Hands!

"The path that the world chooses today will irreversibly mark our children's futures."
Stella Hartinger, The Lancet, 2019



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- Oxford University 2020 Climate Change

The NHS Patient Safety Conference 2022:
Breaking a culture of defensiveness

SPEAKING NOW

Dr Huw Twamley

Regional Medical Examiner Northwest Critical Care Consultant at NHS Improvement

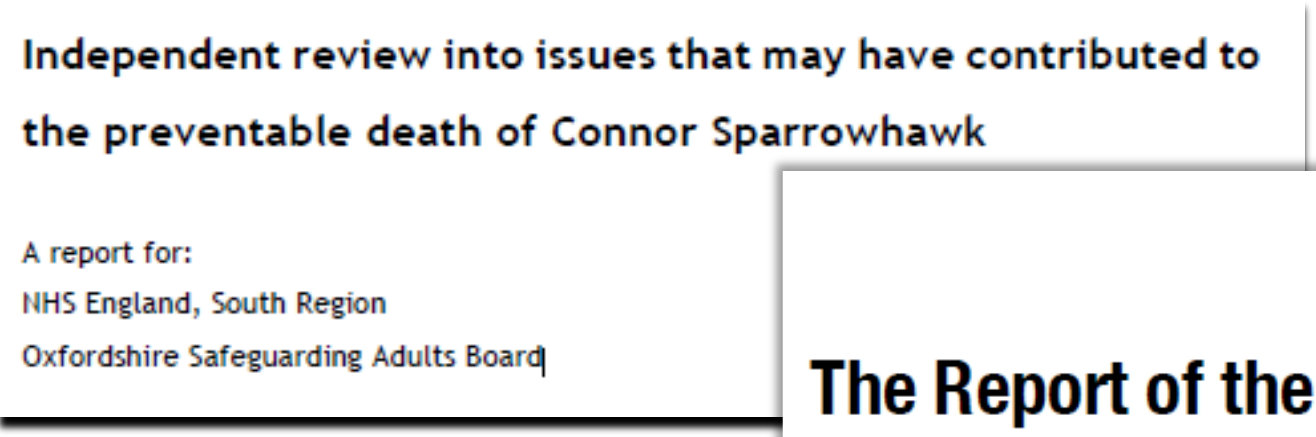
I will be discussing…

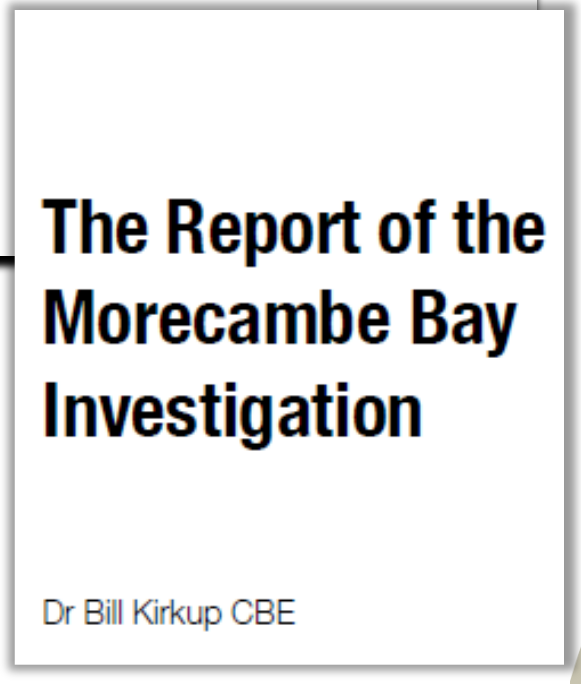
"The National Medical Examiner Programme: Driving Improvement"

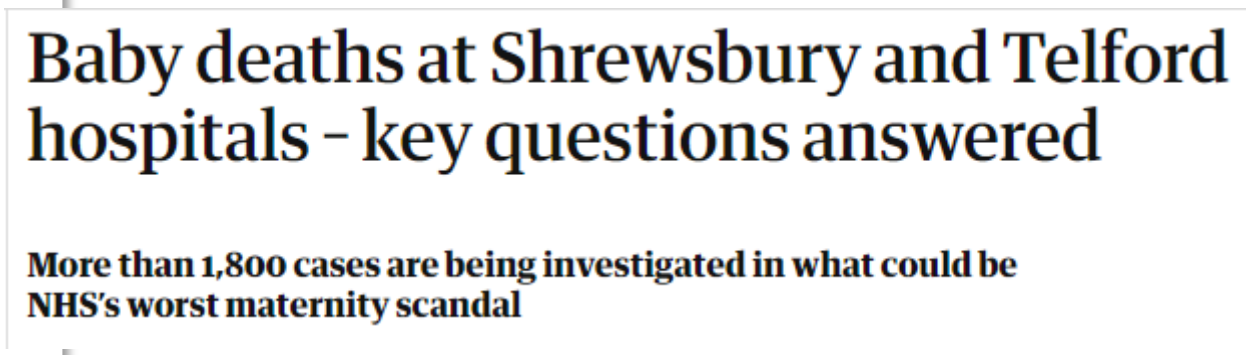
Medical Examiner Services
The Past, Present and Future

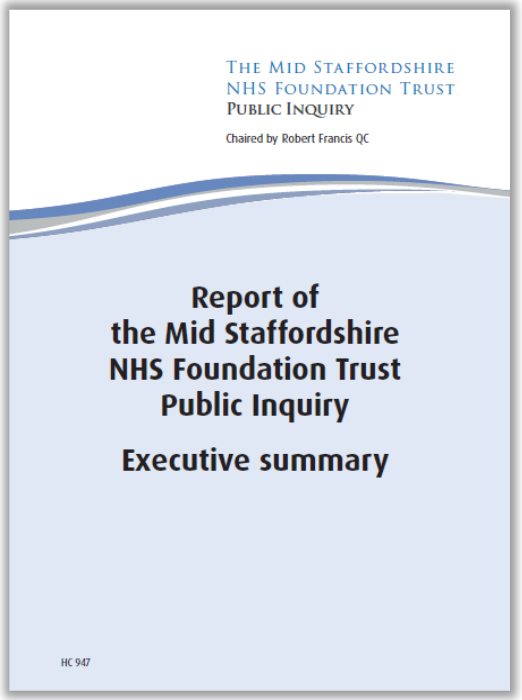
Dr Huw Twamley, Regional M.E. (Northwest)

The not-so-distant past



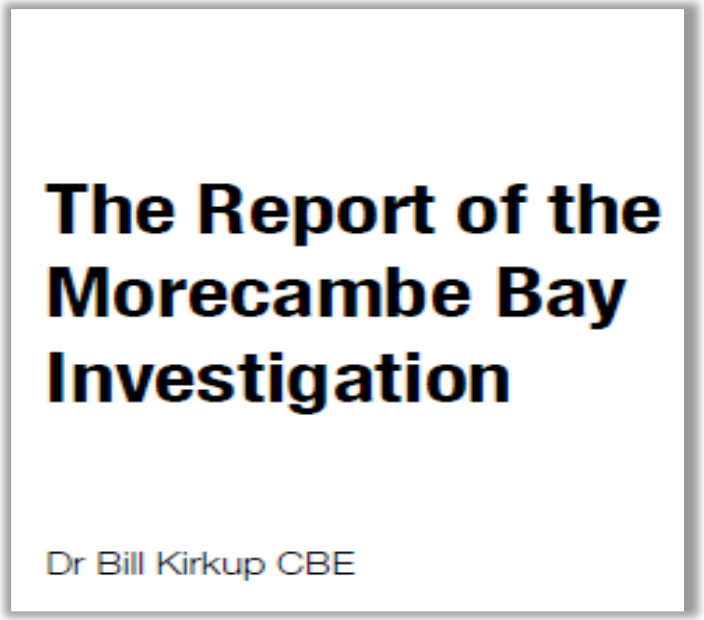






What has changed?

2015



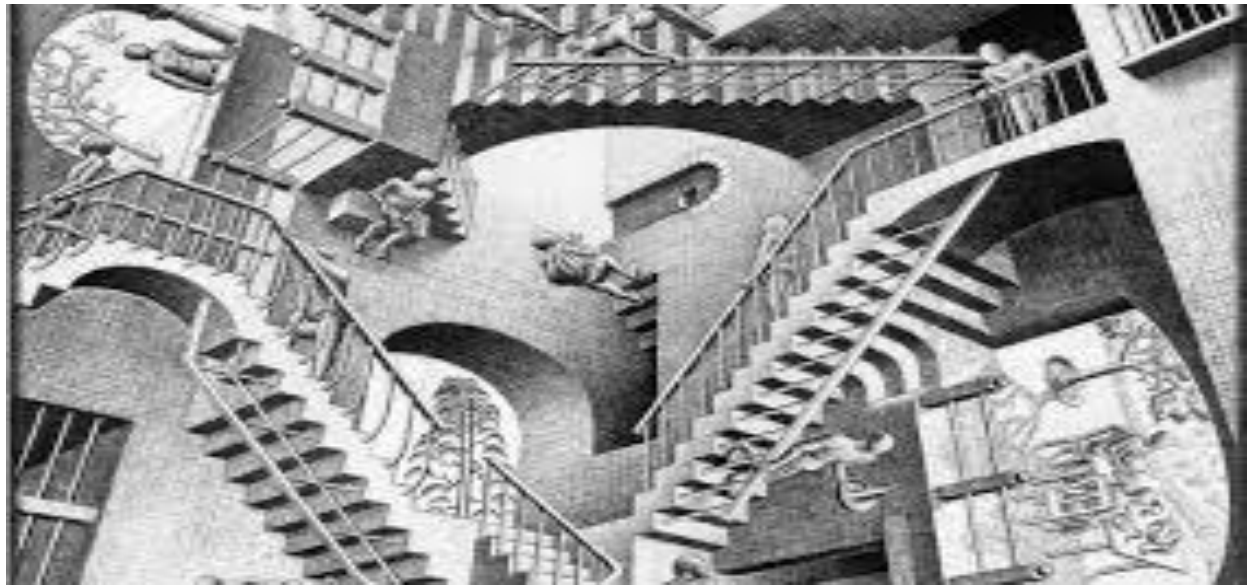
2020

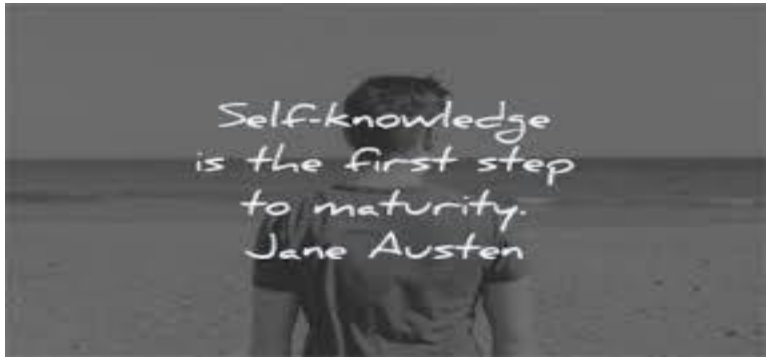
Maternity units 'too defensive' and failing to learn from mistakes

29 September 2020

Illusions

- Illusion of Superiority
- Illusion of Optimism
- Illusion of Control





Key Reflections:

- The ME Programme is an enhancement (not replacement) to existing national Learning From Deaths strategies, Coronial and Regulatory systems
- Key part in patient safety and improvement systems
- Huge opportunity to work across boundaries
- Provides a timely, independent challenge by highly trained, motivated ME teams

The Medical Examiner Office

- Predominantly acute trusts, the office may serve more than one trust
- Medical Examiners
  - Lead Medical Examiner
  - Part time, consultants or GPs
  - Specific on-line and face-to-face training
  - 1 WTE per 3000 annual deaths
- Medical Examiners Officers
  - Lead Medical Examiner Officer
  - Support Medical Examiners
  - 3 WTE per 3000 annual deaths

What do we do?

- Discussion with Attending Practitioner regarding MCCD
- Ensuring appropriate referrals to the Coroner
- Contact with Family to ask about concerns
- Scrutiny of notes to identify issues
- Assurance Independent from Trust

Contact with family

- Can lessen the impact of grief
- Reduces complaints
- Reduces litigation
- Added layer of assurance

Present Situation

- Over 190,000 deaths in Acute settings were scrutinised between 1st April 2021 and 31st March 2022
- Offices established in all Acute Trusts
- Over 1500 Medical Examiner trained.
- Pilot sites starting in Non Acute Settings
- Significant ME and MEO recruitment
- Some regions more advanced
- Around 8000 deaths in non acute settings scrutinised in same time period

Additional issues with Non Acute Roll out

- Notes access including paper records (Lloyd George notes)
- Routes for escalation more varied
- Significant multi-disciplinary care provision
- Shared care responsibility
- Variations between Coroner jursidictions

Impact

- Reduction in MCCD rejection
- Significant Complaint avoidance
- Cases referred to Coroner as a result of scrutiny
- Improved working with Coroner system

- Nearly 500 patient safety incidents identified as the result of scrutiny in Q4
- Themes identified Delayed diagnosis, delays in transfer, loss to Follow up and issues with coordination of care services.

Scrutiny of notes

- A 66 year old woman with a long history of COPD from a life time of cigarette smoking was admitted with severe shortness of breath. She also had CKD, IHD and Peripheral vascular disease.
- This is the third admission in the last six weeks for an acute exacerbation despite having a home nebuliser, antibiotics and regular visits from her GP. Her blood gas saturations were very poor but ITU declined to admit her for ventilation. She died 36 hours after admission and the husband was very angry and upset, claiming she hadn’t received full treatment.

Points from scrutiny

- Did she get appropriate treatment?
- Consultant led review and management plan?
- Appropriate treatment limitation?
- Poor communication (isolated or theme)?
- Admission avoidance?
- Evidence of gold standard framework?
- EOL care good?
- Recognition of end of life?
- Unnecessary investigations?
- Any good aspects of care top feedback?
- Not part of delegated authority
- Review of complete notes not death summary

Options available after scrutiny

- No further action
- Difference of opinion over MCCD
- Structured judgement review (Learning)
- Raising of clinical governance (Harm)
- Safeguarding
- Responsible officer
- Coroner referral (Unnatural Element)
- Police referral (criminal act)

Health and Social Care Bill

Bill passage

Bill started in the House of Commons

- 1st reading
- 2nd reading
- Committee stage
- Report stage
- 3rd reading

Bill in the House of Lords

- 1st reading
- 2nd reading
- Committee stage
- Report stage
- 3rd reading

Final stages

- Consideration of amendments
- Royal Assent

Key

- Complete
- In progress
- Not applicable
- Not yet reached

Other Potential Reforms requiring Secondary Legislation

- Medical examiner scrutiny will be a compulsory legal process before a death can be registered
- ME scrutiny will replace Cremation forms
- Medical Crematorium referee system will cease after a transition period.
- Removal of the need for examination of the body for MCCD/Cremation
- Digital MCCD
- Online registration of death (or hybrid)

In Summary

- Medical Examiners and their Officers are here and working in an acute Trust now
- The ME Service is an enhancement to the existing system of governance and regulation
- Aid quality improves across Integrated Care Systems
- Driving quality improvements by linking active review of treatment and care especially prior to and at the end of life
- Non Acute roll out will support further improvements (anticipated statutory basis 2022-23)

Slido

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The NHS Patient Safety Conference 2022

SCAN ME

8th July 2022- 08:00am – 15:30pm – Mercure Manchester Piccadilly Hotel

Conference hosted by Convenzis Group Limited

THANKS FOR ATTENDING

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