



**PRESS RELEASE**

**16 February 2010**

## **NHS FAILING TO IMPLEMENT PATIENT SAFETY ALERTS**

Action against Medical Accidents (“AvMA” - the charity for patient safety and justice) – has today published a damning report on NHS bodies’ failure to implement patient safety recommendations issued by the National Patient Safety Agency (NPSA). Their report “Adding Insult to Injury – NHS failure to implement patient safety alerts” is based on a Freedom of Information request the charity made to the Department of Health, which manages the Central Alert System (CAS). When the NPSA issues an alert (which is only done after thorough research and consultation that the issues are serious and the recommended actions urgent in the interest of safety), NHS bodies have to report to the CAS when the recommended actions have been completed. Compliance with implementing the alerts within a given deadline is one of the top “core standards” which all NHS trusts in England are supposed to meet.

AvMA sought information about all patient safety alerts issued since 2004 when the system began, where the deadline for completion of actions had already passed at the end of 2009. Key points found from the research into the 53 alerts include:

- Over 300 NHS trusts (around three quarters of all trusts in England) had not complied with the required actions in at least one patient safety alert for which the deadline had already passed.
- There are 2,124 separate incidences of patient safety alerts not having been complied with by NHS trusts.
- 80 NHS trusts had not complied with 10 or more separate alerts. 35 of these trusts have ‘Foundation Trust’ status.
- One trust, University Hospital Coventry and Warwickshire NHS Trust had not complied with 37 (70%) of the alerts. Two others, the Lewisham Hospital NHS Trust and Greenwich Teaching PCT, each failed to comply with 31 (58%) of the alerts.
- There are over 200 incidences of NHS trusts who have not complied with alerts which are over five years old (issued before December 2004).

- There is no system for monitoring implementation of alerts, or of intervening with NHS trusts who have not implemented required actions from patient safety alerts (even those with large numbers of outstanding alerts and alerts which are years past the deadline). Neither is there a robust system for checking that NHS trusts who declare themselves as being compliant actually are.
- The information about which trusts have or have not implemented the alerts is not publicly available, which is why we had to make a request under the Freedom of Information Act.

AvMA Chief Executive, Peter Walsh, said:

“The fact that so many NHS bodies are failing to comply with potentially life saving alerts from the National Patient Safety Agency is shocking. It is putting lives at unnecessary risk and adds insult to injury for patients who have been harmed or lost loved ones as a result of NHS lapses in safety. We all know that mistakes can happen, but there can be no excuse for not acting on patient safety alerts. It is also incredibly worrying that there is no system in place to monitor compliance with these alerts and to intervene where necessary. It is this kind of complacency which could allow another Stafford to happen. We have written to the health minister with responsibility for patient safety, Ann Keen MP, with a set of urgent recommendations which we hope to discuss with her shortly”.

## **CASE STUDIES**

### Lisa Richards-Everton re: her husband’s death

Lisa Richards-Everton’s husband Paul died in July 2007 as a result of a medication error in the Heartlands hospital, West Midlands. In March 2007 the NPSA issued its patient safety alert ‘Promoting the Safer Use of Injectable Medicines’. The basic good practice it recommended might have averted Paul’s untimely death, were it followed. The deadline for completion of the actions was March 2008. Yet as at 29<sup>th</sup> December 2009, 104 of relevant trusts had not completed the actions.. As a direct result of Paul’s and another patient’s death, the NPSA issued a “rapid response alert” in September 2007. All hospital relevant trusts were meant to have implemented the alert’s recommendations by October 2007. As at 29<sup>th</sup> December 2009, 10 still had not. Lisa Richards-Everton said:

*“This report is shocking it shows how the Government and the NHS are failing everyone. Paul’s death could of been so easily avoided if there was a safe system in place, its to late for Paul but not for everyone else. This is clear evidence the systems that are currently in place are inadequate, and urgent changes need to be made. These are people’s lives we are talking about, everyone deserves to be safe in Hospital, we trust adequate safety measures are in place but clearly this is not the case. I will continue to fight until*

*adequate safety measures are in place, so other families do not go through the same tragedy.”*

#### Dr Stuart Gray re: his father's death

Dr Stuart Gray's father Mr David Gray was killed by a massive overdose of diamorphine administered by an out of hours GP from Germany. The death could have been avoided if patient safety alerts already passed the deadline date had been implemented. Dr Gray said:

*"It is deeply disturbing to be informed that so many NHS bodies still completely disregard the NPSA safety alerts. The NPSA alerts are issued for a reason - to prevent deaths and morbidity from unsafe clinical practices and procedures. They are not issued lightly, but after careful consideration and consultation once a safety issue has been identified. I cannot comprehend why any NHS body would choose to ignore them. In fact, I would go so far as to say that I find it personally deeply offensive that they would do so, especially in light of the fact that my father was killed by being administered a massive drug overdose of diamorphine, a potent analgesic, in a situation where the OOH provider was not carrying the drug in line with NPSA guidelines.*

*It is only a matter of time before another death occurs because an NHS body chooses to ignore these alerts.*

*Of particular personal concern is that Worcester Acute Hospitals NHS Trust is one of the worst offenders, the Trust whose area my family and I reside in. I find it repugnant that my family are exposed to these safety risks by this Trust's negligent disregard of the NPSA alerts.*

*Procedures must be put in place by the DoH to ensure complete compliance with the NPSA alerts by NHS bodies. And I would consider any death that, God forbid, should occur through the failure to comply with an NPSA alert to be one of corporate manslaughter by the NHS body concerned."*

#### Amanda Cale re: her father's death

Amanda Cale lost her father as a result of problems with the drug Methotrexate. Her efforts to ensure lessons were learnt to protect others was in large part responsible for one of the first alerts issued by the National Patient Safety Agency. Here she tells her own story:

*"The death of my father Charles Bootle was officially recorded as Methotrexate induced Pneumonitis, in other words the drug he was taking to relieve his Rheumatoid Arthritis caused him harm.*

*The NPSA worked long and hard to alleviate the potential problems associated with this otherwise useful drug, culminating in the first Patient Safety Alert issued for a drug, in July 2004. The recommendations and action plan devised in this alert were to be implemented by March 2005. However in*

*June 2006 the alert was re-issued due to the fact that 18 per cent (104 out of 569) of NHS organisations in England had still not reported having fully implemented the actions set out in the patient safety alert. I have just been informed that as at December 2009 23 trusts have still not implemented the recommendations. Until they do more people may continue to be needlessly harmed by a drug given to help alleviate their pain. I fully support the NPSA and the sterling work they do, and cannot understand why the powers that be have not given them the support they need by introducing compulsory compliance with a method of chasing up and monitoring the results. The alerts are not produced to make more paperwork for hospital administrators, they have been raised to save REAL people from REAL harm!*

*I am also extremely concerned about the fact that the private healthcare industry does not appear to be obliged to implement any of the Patient Safety Alerts! This is laughable when you consider that many people pay to 'go private' believing they will receive a better level of care than within the National Health Service."*

**ENDS**