NHS England

Summary of Minutes of the Patient Safety Steering Group held at Wellington House on Monday 15th July 2014

Present

- Josephine Ocloo – Lead for Developing Patient Safety Champions Network, Imperial College London (Co-Chair)
- Mike Durkin – Director of Patient Safety, NHS England (absent for first half of meeting)
- Martyn Diaper – Medical Director (Quality), Southern Health NHS Foundation Trust (acting chair)
- Paul Farmer – Chief Executive Officer MIND and Chair Mental Health Patient Safety Expert Group
- Linda Patterson - Immediate past Vice President, Royal College of Physicians and Chair Medical Specialties Patient Safety Expert Group
- Shelagh Morris – Deputy Chief Allied Health Professions Officer
- Cate Quinn – CQC
- Suzanne Shale - Ethics Advisor
- Mike Davis - Patients and Public Representative
- Clare Marx – President, Royal College of Surgeons
- Charlotte Augst – Voluntary Sector Representative
- Steve Fairman – Director, NHS IQ
- Juliet Beal – Director of Nursing, NHS England
- Suzette Woodward – Director, Sign Up to Safety Campaign
- Fiona Thow – Patient Safety Collaborative Delivery Lead, NHS IQ

Apologies

- Gill Harris - Regional Director of Nursing, North, NHS England
- Tim Hillard – Consultant Gynaecologist, Poole Hospital and Chair Women's Health Patient Safety Expert Group
- Martin McShane - Director of Long Term Conditions, NHS England
- Lisa Hughes – Associate Director, Education and Quality
- Celia Ingham Clark – Director of Reducing Premature Mortality, NHS England
- Neil Churchill – Director of Patient Experience, NHS England
- Neena Modi – Vice President, Science and Research, Royal College Paediatrics and Child Health and Chair Children and Young People Patient Safety Expert Group
- Sue Hill – Chief Scientific Officer, NHS England
- Bruce Warner – Deputy Director, Patient Safety, NHS England
- Keith Willett – Director, Acute Episodes of Care, NHS England
- John Stewart – Director of Quality Framework, NHS England

In attendance

- Joan Russell – Head of Patient Safety, NHS England
- Paola Brolis – Admin Support Manager, NHS England (Minutes)
- Hannah Thompson – Team Coordinator, NHS England (Minutes)
- Helen Morrison – National VTE Prevention Programme Manager Patient Safety, NHS England
- Jit Patel – Deputy Director of Patient Safety, NHS England
- Steve Tomlin – Consultant Pharmacist, St Thomas Hospital
- Julie Windsor – Patient Safety Lead, NHS England
- Lisa Hughes – Strategy lead, HEE
- Suzanne Kirwan – NHS IQ
- Matt Fagg (Deputy for Celia Ingham Clark) – Deputy Director, Domain 1, NHS England
- Johnathan Frost (Deputy for Tim Hillard) – Registrar in Obstetrics & Gynaecology, Gloucestershire Hospitals NHS FT
- David Bramley (Deputy for Martin McShane) – Domain Team Lead, NHS England

Item A	**Welcome and Introduction** Joan Russell gave apologies on behalf of Mike Durkin that he was unable to be there for the majority of the meeting. Martyn Diaper had agreed to act as Chair for this meeting. The Co-Chair welcomed everyone to the meeting and introductions were made. Declarations of interest were sought and none were raised.
Item B	**Minutes from last meeting** Minutes of the last meeting were approved as accurate. An update on actions from the previous meeting was provided. **Action 1** Further concerns were expressed that the Duty of Candour would not incorporate ongoing retrospective cases. *Post meeting clarification:* • *If an incident causing harm pre-dates the enactment date, but comes to light post enactment, the statutory duty of candour will not apply to that incident* • *A new case post the enactment date would be covered, but a pre-enactment historic case linked to the new case would not be covered* CQC is planning to go out to consultation on its guidance on Duty of Candour and Fit and Proper Persons Test and our general provider guidance at the end of July, subject to DH clearance. **Actions 4, 5 & 6** These will be taken forward as project planning for Phase 2 of the Patient Safety Website commences.

	Action 8 Paper on potential levers has been drafted and will be circulated once approved. All other actions closed.
Item C	**Update on VTE work programme** Helen Morrison provided an update on the National Venous Thromboembolism (VTE) Prevention Programme. The aim of this programme is to reduce mortality and morbidity from VTE. This is done by ensuring that all adults admitted to hospital are assessed for risk of VTE so that appropriate preventative treatment can be given in line with national clinical guidelines and outcomes can be improved. Particular areas of the work highlighted were: • The success of the Commissioning for Quality and Innovation payment (CQUIN) in achieving high compliance with VTE assessment and the potential challenges now that it has been removed. • The e-learning programme that will be available later this year Helen Morrison presented the group with three options for the next steps for the programme, which will be discussed at the next VTE board meeting. • Option 1 Close the Programme • Option 2 Continue for at least another 2 years within same remit • Option 3 Extend remit over 5 year period to cover whole care pathway for VTE Queries and issues raised included: consensus that appropriate prophylaxis is a concern, whether the programme should be wider than secondary care, patients should have a role in ensuring assessment, the need to evaluate the e-learning programme. Option 2 was endorsed by the Patient Safety Steering Group with priorities for the programme being measuring rates of prophylaxis (audit) & VTE outside secondary care setting. It was agreed that there could be an opportunity to align this work with 'Sign up to Safety'.
Action 1	**Members of the Patient Safety Steering Group to contact Helen Morrison with ideas/ suggestions to contribute to or support a continued programme.**
Item D	**"E-prescribing chemotherapy for children" Children and Young People Patient Safety Expert Group** Steve Tomlin updated the group about a concern that has been raised over trusts' ability to comply with NICE guidance on prescribing chemotherapy electronically in paediatrics. The requirement for compliance is coming through the Clinical Reference Groups and there is currently only one electronic prescribing system that is fit for purpose in paediatrics. This is creating potential resource issues and a concern that a financial driver will motivate trusts to implement electronic systems before they are fully tested.

	The group queried whether NICE were aware of this issue and had identified a way forward and what the evidence base was that e-prescribing worked. Steve Tomlin clarified that Keith Ridge, NHS England Chief Pharmacist, is aware of this issue and it was agreed that he would be the most appropriate person to take forward the concerns from the Patient Safety Steering Group.
Action 2	**NHS England to take the concerns raised at the Patient Safety Steering Group forward with the NHS England Chief Pharmacist.**
Item E	**"Second victims of patient safety incidents" Medical Specialities Patient Safety Expert Group** Linda Patterson shared the use of the term "second victims" with the group to define healthcare providers involved in unanticipated medical errors or adverse events who subsequently feel traumatized by their experiences and frequently feel personal responsibility for the patient outcome. This can result in loss of confidence, insomnia and reduced job satisfaction Evidence demonstrates that when these healthcare providers are not appropriately supported after an adverse event occurs this can cause an increase in immediate risk to patient safety and longer term consequences to the safety culture. Linda Patterson asked that the Patient Safety Steering provide support through NHS leaders and professional bodies. Discussion took place and it was strongly felt that the terminology 'second victim' wasn't appropriate from a patient perspective and new terminology should be identified which should be bound in openness and transparency. It was agreed that training, education and enhanced learning was required to support the existing workforce. The option of disclosure coaches was raised. The group was informed of educational packages being developed by Health Education England and Department of Health. It was recognized that this could also be addressed through 'Compassion in Practice'. It was agreed that this should be discussed at individual PSEG's and their views brought back to the next meeting.
Action 3	**Suzanne Shale to circulate draft paper Involved Professionals**
Action 4	**Chairs to take to next Patient Safety Expert Groups and bring feedback to the next meeting**
Action 5	**Circulate link to 'Intelligent Kindness' produced by Royal College of Psychiatrists**
Action 6	**Jeremy Nolan, leading on work at Department of Health, to be invited to the next meeting**
Item F	**"Making parity of esteem a reality for safety" Mental Health Patient Safety Expert Group**

	Paul Farmer briefed the group on the proposed plans for the work of the Mental Health Patient Safety Expert Group. • The commitment by NHS England to the delivery of Parity of esteem in line with the mandate • The requirements of implementing the recommendations of the Francis Review and Winterbourne View Enquiry in mental health, acute and community settings • The current pressures on mental health services and the potential for risk and safety issues to arise • Challenges around gathering accurate and reliable data • Introduction of new policy initiatives including on restrictive practice Issues raised on discussion included what specific evidence existed on patient safety issues affecting particular groups such as those from minority ethnic backgrounds and how this linked to issues of parity of esteem, the wider patient safety issues relating to transition for children and young people using mental health services and the physical needs of patient in mental health services. An example raised was that black males are disproportionately subject to use of a section. It was queried whether there are currently any learning packages available for the priorities raised and what could be included in an improvement programme for Sign up to Safety. Paul Farmer indicated that this should be crisis in care and quality of data. The group were informed of the NHS England Winterbourne View Steering Group that has now been established and chaired by Juliette Beal. It was agreed that the other Patient Safety Expert Groups would find a short list of priorities useful for them to consider at future meetings
Action 6	**Paul Farmer to identify a short list of priorities for Patient Safety Expert Groups to consider**
Item G	**"Using standardised task lists for safer discharge letters" Primary Care Patient Safety Expert Group** Martyn Diaper brought to the group a concern, initially highlighted by a letter from the Medical Protection Society, over breakdown in communication relating to follow up of test results during handover from secondary to primary care. Although information is normally provided in discharge letters this can be lost in other information being shared. The Medical Protection Society had proposed the use of a checklist at the end of the letters to outline what medication and follow up treatment the patient requires. A query was raised as to whether patients and their relatives were routinely being sent copies of discharge letters and results and whether there are currently systems in place to monitor this. Martyn Diaper asked that the Patient Safety Steering Group and other Patient Safety Expert Groups provided support to the Primary Care Patient Safety Expert Group in taking this forward.

	It was suggested that up to 40% of discharge medication information is inaccurate. It was reflected that a long-term solution is for primary and secondary care information systems to be able to interrelate. It was also recognised that the quality of information provided to patients is key to improvement. In mental illness, there is a national CQUIN in 2014/15 covering assessment of physical needs and coding, which aims to improve flows of information from mental health inpatients to primary care. It was agreed that a standardised process for specific information requiring follow up needs to be established and that this would form part of the wider work on handover being led by the Patient Safety Domain. Joan Russell informed the Group that she is meeting with Health Watch England to discuss the work they are currently undertaking on discharge.
Action 7	**Chairs to discuss with their Patient Safety Expert Groups**
Action 8	**Joan Russell to meet with Health Watch England**
Item H	**"Junior Doctors and Escalation" Surgical Services Patient Safety Expert Group** Clare Marx shared a concern that has arisen from the Surgical Services Patient Safety Expert Group relating to when and how junior doctors escalate patients' deterioration. Concerns included skills in recognising that a patient was deteriorating which are wider than responding to the current MEWS scoring systems. Concerns had also been raised over current training provided to junior doctors in how to escalate and for senior clinicians in how they respond. It was recognised by the Patient Safety Steering Group that this issue was relevant to both medical and nursing staff. It was agreed that this is an area of shared concern that needs to be addressed, although it is acknowledged that mortality is reducing since the introduction of MEWS. It was agreed that undergraduate and postgraduate curricula needs to be improved. It was suggested that skills on visual assessment of deterioration need to be addressed at undergraduate level and that training should be multidisciplinary. Training should also be provided on raising concerns that requires cultural change within professions and teams. It was recognised that the GMC could also have role in supporting this issue through revalidation. It was also suggested that this would be an ideal topic for the Patient Safety Collaboratives to take forward.
Action 9	**Health Education England to explore opportunities for inclusion in training programmes and feedback at next meeting**
Item I	**"Never Events retained vaginal swabs" Women's Health Patient Safety Expert Group**

	Jonathan Frost gave a presentation about reducing the risk of retained swabs after vaginal birth and perineal suturing, as this is the 3rd most common sub-category of Never Event that occurs. 25% of these procedures are undertaken in a non theatre environment. This problem commonly presents later when the patient is either in pain or there are signs of infection. Jonathon Frost with Michelle Upton, Maternity and Neonates Patient Safety Lead, has recently undertaken a review of the never events that have been reported. Potential actions, identified from the review, to reduce these Never Event include: • Having written procedures for swab counts • Audit of swab count practices • Provision of education and training • Ensuring documentation of the swab count • Risk assessing sterile delivery and perineal suture packs • Ensuring staff report incidents for learning The group agreed that the next steps to reduce the risk of this event from occurring are as follows: • Further information to be gathered from trusts to allow in depth analysis of previous incidents and thematic analysis • NHSLA analysis of claims relating to retained vaginal swabs • Survey current practice / establish examples of good practice • Recommendations to national standards for operating department practice steering/ writing groups • Further implementation of the NPSA WHO Maternity Checklist • Professional leadership
Action 10	**Jonathon Frost to share agreed actions with Women's Health Patient Safety Expert Group**
Action 11	**Juliet Beal to take professional leadership elements forward for nursing and midwifery**
Item J	**Points of Clarity from Briefing** No points of clarity were raised. Joan Russell asked whether members found these briefings useful and the group confirmed that they do.
Item K	**Any other Business** Date of next meeting: Monday 20th October 14:00- 16:30 at Skipton House room 136B;137B

Signed: _____ Dr Mike Durkin

Dated: _____