

NHS England

Summary of Minutes of the Patient Safety Steering Group held at Skipton House on Tuesday 20th January 2015

Present

- Mike Durkin – Chair, Director of Patient Safety, NHS England
- Josephine Ocloo – Lead for Developing Patient Safety Champions Network, Imperial College Health Partners London (Co-Chair)
- Ben Thomas – Chair Learning Disabilities Patient Safety Expert Group
- Celia Ingham-Clark – National Director of Reducing Premature Mortality, NHS England
- Charlotte Augst – Voluntary Sector Representative
- Clare Marx – President, Royal College of Surgeons and Chair Surgical Services Patient Safety Expert Group
- Fiona Smith – Chair of Infant, Children & Young People Patient Safety Expert Group
- Martyn Diaper – Medical Director (Quality), Southern Health NHS Foundation Trust and Chair Primary Care Patient Safety Expert Group (acting co - Chair)
- Linda Patterson – Chair Medical Specialties Patient Safety Expert Group
- Paul Farmer – Chief Executive Officer MIND and Chair Mental Health Patient Safety Expert Group
- Phil Duncan – Patient Safety Collaborative Lead NHS Improving Quality
- Gill Harris - Nursing Director North Region, NHS England

Apologies

- Sue Hill – Chief Scientific Officer, NHS England
- John Stewart – Director of Quality Framework, NHS England
- Shelagh Morris – Deputy Chief Health Allied Health Professions Officer, NHS
- Andy Mitchell – Regional Medical Director (London Region), NHS England
- Roopen Arya – Director of Thrombosis, King's College Hospital
- Bruce Warner – Deputy Chief Pharmaceutical Officer, NHS England
- Fiona Thow – Patient Safety Collaborative Delivery Lead, NHS IQ
- Keith Willett – Director, Acute Episodes of Care, NHS England
- Paula Mansell – Themed Inspection Manager, CQC
- Steve Fairman – Director, NHS IQ
- Suzanne Shale - Ethics Advisor
- Lisa Hughes – Associate Director, Education and Quality
- Suzette Woodward – Director, Sign Up to Safety Campaign
- Tim Hillard – Consultant Gynaecologist, Poole Hospital and Chair Women's Health Patient Safety Expert Group
- Juliet Beal – Director of Nursing, NHS England

In attendance

- Joan Russell – Head of Patient Safety, NHS England
- Harpreet Sood – Senior Fellow, Chair & Chief Executive's Office
- Ijeoma Ajibade – Special Projects Manager, Healthwatch
- Simone Belshaw – Business Coordinator, Healthwatch
- Jennifer Benjamin – Quality Improvement Team DoH
- Julie Windsor – Patient Safety Lead – Falls and Older People
- Michele Upton – Patient Safety Lead – Maternity & Newborns
- Anita Dougall – Director, Clinical Quality, RCOG
- Renee Knopp – Programme Lead – National Programmes
- Diane Parsons – Team Coordinator, NHS England

Item A	<p>Welcome and Introduction</p> <p>Mike Durkin welcomed everyone to the meeting and introductions were made.</p> <p>Apologies were received as list above.</p>
Item B	<p>Minutes from last meeting</p> <p>The following feedback was received:</p> <ul style="list-style-type: none"> • Josephine Ocloo advised that her title should be Imperial College Health Partners <p>These changes were accepted and minutes were otherwise approved as accurate.</p> <p>An update on actions from the previous meeting was provided</p> <p>Action 2 Acknowledgement has been received from NMC and GMC to letters sent with regards to inclusion of patient safety in examination questions</p> <p>Action 5 The proposed Patient Safety Alert on availability of medical devices is now being reconsidered</p> <p>Action 12 There is still concern over the term 'second victim'. It is recognised that this is potentially difficult to change as now well recognised and used in literature. Any ideas on alternative names are welcomed and all are encouraged to share useful resources. Mike Durkin agreed to write to Health Education England to request that they take this work forward.</p> <p>All other actions were either on the agenda or closed.</p>
Action 1	<p>Chair of Patient Safety Steering Group to write to Health Education England</p>
Item C	<p>Resources to support implementation of Duty of Candour</p> <p>Jennifer Benjamin provided an overview of current activity at the Department of Health in relation to Duty of Candour. The legal duty came into force on Nov 14th and CQC have now published guidance on the definition and requirements. An initial procurement process for resources to support Duty</p>

	<p>of Candour didn't identify a preferred provider.</p> <p>Current views are that any supporting resource needs to clarify that the emotional and welfare needs of both patients and staff are being met. There is also a need to be able to clarify impact and sustainability of statutory requirements. It has been recognised that initial timescales for development of resources were too tight as they need to address both staff training and organisational change.</p> <p>Any funding required will be prioritised in budget for 2015/16.</p> <p>Jennifer asked for views on whether the proposed approach is sufficiently patient centred, whether there are alternative approaches and how we can ensure that openness and candour are truly embedded.</p> <p>Feedback received from the Patient Safety Steering Group included:</p> <ul style="list-style-type: none"> • The complexities of implementing when patients are being cared for by social services • Lack of clarity for patients about how to report PSIs in primary and social care and them knowing whether these have been recorded and any action taken • What consideration has been given to measurement as this shouldn't be undertaken through regulation • Ensuring implementation should be a local process with CCGs taking responsibility for ensuring processes in place • General practice is a key area to engage with • Need for policy and resources to support assurance that policy has been implemented • Resources should be an enhancement of existing systems • Opportunity to build into Patient Safety Collaboratives and AHSNs should be explored • Something needed to support professional recognising that they're emotionally charged • The Royal College of Surgeons are producing a piece of work on how the Duty of Candour relates to professionals which can be shared • Further guidance required on how to deal with those who have been harmed • The need for harmed patients to be involved in developing guidance and implementation resources
Action 2	Clare Marx to share the draft work being undertaken by Royal College of Surgeons
Item D	<p>Points of clarity from briefings</p> <p>Josephine Ocloo went through each of the briefs in turn asking if anyone required further clarity on the information provided.</p> <p>Acute Kidney Injury Programme Board</p> <p>Joan Russell updated the group that the intent to publish a national CQUIN for AKI was announced at the last NHS England Board meeting</p>

Item E	<p>Healthwatch UK report on unsafe discharge from hospital, care home or mental health setting</p> <p>Presentation given by Ijeoma Ajibade, Special Projects Manager, Healthwatch and assisted by Simone Belshaw, Business Coordinator, Healthwatch.</p> <p>An overview was provided of the approach taken to this enquiry and it was clarified that the focus was mental health, elderly and homeless people. The presentation focussed on the mental health element of the enquiry with a few highlights shared from the homeless. The older and homeless people briefings won't be available until the end of January 2015.</p> <p>Key findings from the enquiry included:</p> <ul style="list-style-type: none"> • Some people are discharged too quickly • Lack of support for patients after discharge • People are kept in mental health establishments for longer than necessary • Communication breakdown between hospitals and community mental health teams • People not involved in decisions that affect their lives and future • Stretched community mental health teams and acute wards working at full capacity • Homeless people experience lack of compassion from hospital staff • Homeless people do not have anywhere to stay and recover and discharged onto street <p>This was followed by questions and discussion from the group.</p> <p>It was agreed that this is an important piece of work. The report highlights particular issues relating to accelerated discharge and the importance of communication across sectors. It is unacceptable that people are still discharged onto the street and that home systems are not available.</p> <p>A query was raised over how these issues can be embedded into NHS Governance and at what point do inadequacy in health systems become a safety issue. Another query was raised as to whether the report would identify those who took discharge against medical advice and there was some discussion as to whether this should be reported as a patient safety incident.</p> <p>The presenters were asked what the next steps would be in taking forward findings and recommendations from the report through Healthwatch special powers. It was confirmed that a legacy programme was currently being considered which would include a toolkit, discussions with CQC and more work with the voluntary sector.</p> <p>It was agreed that once the report was published NHS England should consider how it can work together with Healthwatch over issues identified. There may be opportunity to take work forward through the Patient Safety Collaboratives.</p>
Action 3	<p>Briefings on older people and homeless and final report to be circulated when published</p>

Item F	<p>Five Year Forward View</p> <p>An overview of the Five Year Forward View was given by Harpreet Sood, particularly focussing on the relevance to patient safety. The overview included:</p> <ul style="list-style-type: none"> • The context over current increase in delivery and demand for care • New opportunities in technology and treatment and methods of delivery of care • Current financial challenge of projected £30 billion gap by 2020/21 • The need for radical upgrade in prevention, new models of care and efficiency and investment • New models of care include multispecialty community providers, primary and acute care systems, urgent and emergency care networks, further specialised care, viable smaller hospitals, modern maternity services and enhanced health in care homes • The need for a new type of partnership between national bodies and local leaders to implement new care models • Current patient safety initiatives in NHS England that support the requirements identified in the Five Year Forward View <p>This was followed by questions and discussion from the group.</p> <p>It was not fully clear how patients will be empowered to be involved in future change and doesn't appear to be addressing diversity effectively. This will be particularly important in long term conditions, for example where follow up appointments will take place</p> <p>The development of integrated networks may identify more patient transfers between sites. London Region has developed a safe transfer service with London Ambulance Service which may be a useful model to share.</p> <p>Clarity was sought over what was included in the multispecialty community providers as opposed to the integrated primary and acute care systems and also how mental health will be integrated into the different models of care. It was agreed that a joined up approach is needed when delivering the different solutions and some investment will be required to support the mental health pathway. New models will also create challenges to training e.g. the provision of mental health expertise for GPs.</p> <p>It was felt that success will be about creating the conditions to allow people to introduce models of change at a local level. The interface between voluntary and social care will also be crucial.</p> <p>Mike Durkin asked the entire group to reflect on the slides and contact Harpreet Sood directly with further views and queries.</p>
Action 4	<p>All to make contact with Harpreet Sood with any additional views and queries at hsood@nhs.net</p>
Item G	<p>Development of NatSSIPs (for information)</p> <p>The draft National Safety Standards for Invasive Procedures were circulated with the papers for information.</p> <p>Clare Marx provided a brief explanation that the standards have been</p>

	<p>developed in response to recommendations from the Surgical Never Events Taskforce. The standards are currently being informally tested in a small number of organisations prior to more formal simulation testing in March, subject to approval of funding.</p> <p>When finalised, the standards will be expected to create the foundation for the development of local procedures, future education, regulation and commissioning.</p> <p>The Taskforce Reference Group, chaired by Will Harrop-Griffiths, reports into the Surgical Services Patient Safety Expert Group.</p> <p>Joan Russell informed the group that the standards would be presented in more detail at a future meeting when ready to be signed off. It is also essential that the relevant organisations and special societies provide proactive endorsement of the Standards.</p>
Action 5	Joan Russell to invite Chair of Taskforce Reference Group to a future meeting
Item H	<p>Emerging Issue – risks associated with moving location of patients during inpatient episode</p> <p>Linda Patterson provided an overview of an issue that had been discussed at the last Medical Patient Safety Expert Group and the group felt it should be discussed more widely at the Patient Safety Steering Group.</p> <p>With ever present and increasing bed pressures, patients can be put in any available slot. If they don't fit into the speciality, they are likely to be moved again. It is known that this increases length of stay, creates issues of poor handover, poor patient experience and patients can receive poorer care. This usually affects older people with a number of conditions who do not easily fit into single speciality definitions. The view of the Medical Patient Safety Expert Group is that the extensive practice of moving patients is unacceptable and staff often do not feel appropriately skilled to care for these patients.</p> <p>A useful discussion was held in which it was felt that whilst not being condoned there are a number of factors at the moment which make it difficult not to agree to move patients and the issues are complex. These include current bed pressures and bed modelling over number of beds in differing specialties and dependencies and numbers that should be unallocated, the ability to discharge patients in a timely manner due to social service pressures, all of this leading to patient flow problems around the hospital.</p> <p>It was agreed that there are other fora better placed to address this issue and that it should not be led through patient safety. Celia Ingham-Clark agreed to take this forward through the Medical Directorate</p>
Action 6	Linda Patterson to produce an extended brief for Celia Ingham-Clark
Action 7	Celia Ingham-Clark to take forward through Medical Directorate
Item I	<p>Draft Patient Safety Alert “Risk of death from accidental ingestion of fluid/food thickening” – for approval</p> <p>Julie Windsor provided an overview of the background that had led to the</p>

	<p>draft Patient Safety Alert being developed. In the trigger incident NHS England had received details of an incident where a care home resident died following the accidental ingestion of the thickening powder that had been left within their reach. The Alert had been sponsored by the Medical Patient Safety Expert Group.</p> <p>Useful discussion was held and the feedback received was that whilst the Steering Group didn't have any specific concerns over the contents of the Alert they did have concerns over whether use of the Alert system would reach all of the priority audiences for this issue – care homes, community care and industry.</p> <p>It was agreed that the Alert should be issued but that an action plan should also be developed to demonstrate additional action being taken to communicate with these sectors who may not currently receive this information through the Alert system.</p>
Action 8	Julie Windsor to develop an action plan to support the dissemination of the Alert and action to be taken by other sectors
Action 9	Action plan to be circulated to Patient Safety Steering Group for approval prior to final approval of the Alert
Item J	<p>Patient Safety Alert “Button Batteries” – next steps</p> <p>Michele Upton explained that during consultation on this Patient Safety Alert it was identified that up to date national guidance was required over the management of these patients as there was variance in practice.</p> <p>The Patient Safety Steering Group was asked who the most appropriate organisation was to develop national guidance. It was agreed that Toxspace should be approached.</p>
Action 10	Mike Durkin to write to Toxspace
Item K	<p>Any other Business</p> <p>No other business was identified</p> <p style="text-align: right;">Date of next meeting: Tuesday 21st April 2015 14:00pm - 16:30pm at Skipton House Room 136/137B</p>



Signed: _____ Dr Mike Durkin

Dated: _____ Tuesday 28th April 2015 _____