Strategy and Advisory Group

Notes of meeting on 9 September 2015

Wellington House, Waterloo

ATTENDEES

David Dalton (DD)	CEO Salford Royal
Mike Durkin (MD)	NHS England
Penny Pereira (PP)	The Health Foundation
Suzie Bailey (SB)	Monitor
Richard Wilson for Peter Blythin (PB)	NHS Trust Development Authority
Jennifer Benjamin (JB)	Department of Health, Quality
Phil Duncan (PD)	NHS Improving Quality
Rebecca Lawton (RL)	Co-Chair Patient Engagement Group
Adrian Bull	Representing all AHSNs
Denise Chaffer (DC)	NHS Litigation Authority
Martyn Diaper (MD)	NHS England
Cristina Cornwell (CC)	Care Quality Commission
Kevin Stewart (KS)	Royal College of Physicians
Rosie Courtney (RC)	Health Education England
Ged Byrne (GB)	Health Education England
Hannah Thompson (HT)	Sign up to Safety
Dane Wiig (DW)	Sign up to Safety
Suzette Woodward (SW)	Sign up to Safety

APOLOGIES- NON ATTENDERS

Liz Mears (LM)	North West AHSN
Norman Williams (NW)	Chair Patient Safety Collaboratives
Matt Fogarty (MF)	NHS England
Peter Blythin (PB)	NTDA

FUTURE DATES

2015	**2016**
11th November 10.30 – 12.00	27th January 10.30 – 12.00

NOTES

Notes of the JUNE meeting were agreed.

MEASUREMENT

Mike Durkin provided a verbal briefing on the national measurement unit. Key points:

- Funding agreed
- Procurement phase in progress – the national measurement unit will be a core resource but will take time to establish; led initially by NHS England – will transfer with the patient safety team to NHS Improvement
- Priority setting baselines have been finalised and delivered to the AHSNs – each pack is tailored with data drawn from organisations linked to the AHSN footprint
- Data sources include over 14 different datasets
- New national service should be up and running by April 2016
- Interim data pack circulated for the group compiled by Frances Healey; the work of the team at NHS England has sought new ways of thinking about measurement and monitoring of patient safety; recognising the limitations of the current data systems
- National process for case note review also at procurement stage – will involve a nationwide training programme

DISCUSSION POINTS

- The national approach is for self-directed safety improvement, locally led and locally owned – the place for national measurement sits within a small number of agencies e.g. CQC
- Suzie Bailey asked the group to note the work of the NQB which was developing a new quality strategy for England which would include an improvement strategy and references to measurement (SB)
- Measurement for comparison is considered both too simplistic an approach and difficult to do. It creates the wrong culture across the NHS. Learning and spreading best practice are the top priorities (MD)
- We should all agree that we will not be able to count the lives saved (measuring an absence of an event is impossible) – however we will be able to look at trends in deaths over time (AB)
- There are measures beyond the traditional focus – which can provide indicators of safety or a safety culture such as staff wellbeing and patient experience measures (RL)
- Important to focus on building local measurement skills and linkages with the patient safety collaboratives (SW/AB)

NATIONAL PICTURE – ROLE OF QUALITY ACCOUNTS

- David Dalton stated that it would be nice to know if the current set of interventions is making a difference and what could the mechanisms be for understanding this

- It was noted that each organisation that has joined Sign up to Safety has been asked to create local bespoke safety improvement plans – in guidance from the campaign it is suggested that they could make these plans, together with their pledges and progress, public (SW)

- David Dalton proposed the quality accounts[i] as a lever for supporting this action. For 2015/16 – organisations could be asked to consider whether they have a section in their quality account (to be published on June 30 in 2016) on Sign up to Safety and progress against the goal of reducing harm by half and saving lives. This would need to be framed in a supportive way – helping leaders to make it easy to report publically on progress and would also be helpful for any external scrutiny by organisations such as CQC. Note that this may not apply to other areas of care (social care, primary care)

- It was understood that there is a group that oversees the quality account (approach) via the NQB and that they were meeting soon – Monitor and NTDA were members – DD asked for them to consider this proposal

ACTIONS

1. Those members that attend the NQB and the specific group related to the quality accounts were asked to take this proposal to them and report back to this group in November

2. Mike Durkin to share the specification for the measurement unit

3. Mike Durkin to thank Frances Healey and the team for the work on the interim data report

CHANGES AT A NATIONAL LEVEL

Mike Durkin spoke to the paper circulated which described the establishment of NHS Improvement and the patient safety responsibilities that would sit within NHS Improvement. These include; the NRLS, clinical leadership, alignment of patient safety priorities, gaining a better understand of what goes wrong and enhancing NHS capability and capacity to improve patient safety. In addition NHS Improvement will coordinate the new Independent Patient Safety Investigation Service (IPSIS), provide advice on a global patient safety movement and oversight on safe staffing.

Q INITIATIVE

Penny Pereira provided a verbal update and circulated a document related to the Q initiative. The founding cohort has met for their first design meeting and will be meeting for a second two day event in Glasgow in September. Penny will report back at the January meeting on progress.

UPDATE ON SIGN UP TO SAFETY

Suzette Woodward provided an update in relation to the first year of the sign up to safety campaign – a paper with the detail had been shared prior to the meeting. The work of the campaign to date was received very positively.

DISCUSSION POINTS

- The learning from the campaign would be useful to feed into CQCs work on 'well led' and 'safety' assessments (CC)
- The report provided a coherent description of each bit of the system which was felt to be extremely helpful (AB)
- Jennifer Benjamin highlighted the positives of the campaign taking a unique approach to change and said that it has managed to make a difference in terms of scale and has done so at pace – it would be vital to continue to maintain this different approach and to continually learn from this way of working
- The campaign has stimulated local interest and energy and it has demonstrated that there is a place for this methodology as part of the collection of interventions (DD)
- Support for leaders and Boards remains important (but recognised as hard to do) – personalised and targeted approaches would be ideal but again difficult logistically (Monitor and NTDA both offered support which will be followed up by the communications manager of the campaign)
- The campaign has given people permission to look at things differently in safety

PATIENT ENGAGEMENT GROUP

Rebecca Lawton fed back to the group key points from the patient engagement group that she co-chairs with Gerry Armitage. She provided some references related to the points below to read to increase our understanding in this area.[ii]

- Three meetings have been held; the meetings have considered:
    - Patient engagement strategies; the Carman framework was found to be the most relevant
    - Patient reported measures of patient safety; the Scottish Culture Questionnaire was considered as best practice together with the Bradford measurement tool
- The group have commissioned scoping work on good practice for patient engagement in patient safety
- Rebecca will share a reference on Duty of Candour work for Christina Cornwell
- Denise – noted that the negligence claims in the NHS LA database are of themselves patient reported safety data

- Rebecca asked the group to note that (a few of) the members of the Patient Engagement Group had expressed concern about the level of representation of patients at the Strategy and Advisory Group and that there had been some correspondence between DD, RL and GA with the PEG members related to this matter

ANY OTHER BUSINESS

None

NEXT MEETING

11 NOVEMBER 2015 – WELLINGTON HOUSE, WATERLOO

AGENDA TO INCLUDE A PAPER FROM THE HEALTH FOUNDATION ON PATIENT SAFETY

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[i] A Quality Account is a report about the quality of services by an NHS healthcare provider. The reports are published annually by each provider, including the independent sector, and are available to the public. The Department of Health requires providers to submit their final Quality Account to the Secretary of State by uploading it to the NHS Choices website by June 30 each year.

[ii] Links should take you directly to the articles:

Giles, S. J., Lawton, R. J., Din, I., & McEachan, R. R. (2013). Developing a patient measure of safety (PMOS). *BMJ quality & safety*, *22*(7), 554-562.

http://eprints.whiteroseac.uk/76947/7/lawtonr4.pdf

McEachan, R. R., Lawton, R. J., O'Hara, J. K., Armitage, G., Giles, S., Parveen, S., ... & Wright, J. (2013). Developing a reliable and valid patient measure of safety in hospitals (PMOS): a validation study. *BMJ quality & safety*, bmjqs-2013.

https://www.researchgate.net/profile/Sahdia_Parveen/publication/259574321_Developing_a_reliable_and_valid_patient_measure_of_safety_in_hospitals_%28PMOS%29_a_validation_study/links/00b4952caa827d32f0000000.pdf

Lawton, R., O'Hara, J. K., Sheard, L., Reynolds, C., Cocks, K., Armitage, G., & Wright, J. (2015). Can staff and patient perspectives on hospital safety predict harm-free care? An analysis of staff and patient survey data and routinely collected outcomes. *BMJ quality & safety*, bmjqs-2014.

http://qualitysafety.bmj.com/content/early/2015/04/10/bmjqs-2014-003691.full.pdf+html