# MEETING NOTES

**Meeting:** NHS England Medical Patient Safety Board  
**Date:** 13th September 2013

### Attendees:
- Dr Linda Patterson (chair) (RCP)  
- Dr Mark Temple (RCP)  
- Dr Kevin Fox (BCS)  
- Dr John ES White (BTS)  
- Dr Susan Robinson (CoEM)  
- Dr Angela Brown (AvMA)  
- Marisa Mason (NCEPOD)  
- Dr Hilary Bryne (clinical commissioners)  
- Dr Archie Prentice (RCPath)  
- Dagmar Luettel (NHS England)  
- Dr Frances Healey (NHS England)  

### Apologies:
- Dr Kevin Stewart (RCP)  
- Prof David Cousins (NHS England)  
- Emma Boakes (NHS England)  
- Prof David Oliver (BGS)  
- Dr Paul Rylance (Renal Association)  
- Prof Ravi Mahajan (SALG)  
- Dr Adam Harris (BSG)  
- Dr Tricia Woodhead  
- Philip King (CQC)  
- Heidi Wright (RPS)  
- Andrew Hall (RCR)  
- JP Nolan (RCN)  
- Prof Huon Gray  
- Joan Russell

### Item 1: Introduction and apologies

**Apologies:**
- As above  
- Noted still awaiting representative from NHS England Patient Experience Division  

**Actions:**
- JR to pursue NHS England Patient Experience Division representation  
- FH invite representatives from RCP patient group via Suzy Hughes

### Item 2: Accuracy check of last meeting notes and approval

**Agreed as a correct record, and brief action-focused style commended.**  
Group requested notes to be publically available. FH confirmed transparency is the intention although NHS England website still under construction so may be short delay.

Agreed outside meeting Dagmar Luettel (whose Patient Safety Lead role is focused on medical devices and who works closely with MHRA) will act as liaison between the expert group and MHRA, therefore action in last meeting notes of inviting MHRA representative not taken forward.

**Actions:**
- JR to pursue publication area for all expert groups’ agendas and notes

### Item 3: Actions carried forward from June 2013 meeting not on September 2013 agenda

**Access to:** The CoEM and Renal Association have

**All to update the group at:** All

---

The CoEM and Renal Association have agreed to update the group at all points.
<table>
<thead>
<tr>
<th><strong>NRLS data</strong></th>
<th>submitted request for access to NRLS data from their specialist area</th>
<th><strong>future meetings</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MHRA representative</strong></td>
<td>Agreed with chair that Dagmar Luettel (whose Patient Safety Lead role is focused on medical devices and who works closely with MHRA) will act as liaison between the expert group and MHRA</td>
<td>-</td>
</tr>
</tbody>
</table>

**D. New agenda items**

| Terms of Reference | Noted that minor amends requested at last meeting have been made. ToR agreed but the chair noted the challenge now is to make them into a working reality. Noted over-arching group has been established and meets 21\textsuperscript{st} October 2013 | - |
| Overview of Domain 5 Outcomes framework and key types of serious harm | Frances Healey presented a brief overview of NRLS data from medical specialties, focused on death and severe harm, and the findings of the Hogan, Healey, Vincent et al. preventable deaths study. Discussions arising out of this related to thinking on how the expert groups can collectively make a difference, and have been merged with follow-on discussion below. | FH to circulate slides and Hogan et al. paper |
| | | FH has circulated these 13.09.13 |
| Patient safety story | The chair proposed all meetings include patient safety stories, initially drawing from the experiences of group members, and alternating positive and negative experiences. The chair set ground rules for sharing these personal patient safety stories; the group agreed these are shared in confidence and are not to repeated outside the meeting, and will be received in a spirit of mutual support and learning A member of the group shared a powerful patient safety experience and was thanked for their openness and honesty. Rich discussion followed, merging into the next item. | SR agreed to provide the next (positive) patient safety story |
| | | SR |
| The Berwick report | The majority of this discussion will be fed into a draft paper outlining the aims and plans of this expert group to be discussed next meeting, but additional points not captured in this draft were: The primacy of the Francis | Draft paper outlining the aims and plans of this expert group and bring for discussion next meeting |
| | | LP/FH |
report, with the Berwick report constituting advice on the implementation of the Francis report, particularly in respect to safety culture.

- AvMA has concerns about inconsistency between Francis and Berwick on duty of candour issues, including inconsistencies on levels of harm at which a duty of candour applies, which they will formally feed back to the government.

### AOB

Note Ombudsman’s sepsis report [http://www.ombudsman.org.uk/time-to-act](http://www.ombudsman.org.uk/time-to-act)  
FH tabled a paper on proposals for future patient safety Alerts, and circulated this by email immediately after the meeting  
LP recommended reading [http://www.jeromegroopman.com/how-doctors-think.html](http://www.jeromegroopman.com/how-doctors-think.html) | -  
Comment requested from all by Tuesday 24th September | All |

| Current patient safety issues | No current patient safety issues that may trigger national alerts were tabled | - |

| Proposed agenda items for next meeting | i. Positive patient safety story from SR/RB  
ii. Discussion of Surgical Never Events recommendations and their implications for proposed medical invasive procedures checklists  
iii. Presentation on the NHS England Patient Safety strategy from Domain 5 leadership  
iv. Update on respective ‘second victims’ workstreams  
v. Update on CoEM’s set of safety standards | FH/LP to plan agenda and make appropriate invitations | FH/LP |

<p>| Note additional | i. Invite Sir Liam Donaldson to present on Imperial’s approach to | FH/LP to make appropriate invitations | FH/LP |</p>
<table>
<thead>
<tr>
<th>agenda items for future meetings</th>
<th>analysis and development of the NRLS</th>
</tr>
</thead>
<tbody>
<tr>
<td>ii.</td>
<td>Presentations from NHS England medication safety team (including allergy issues)</td>
</tr>
<tr>
<td>iii.</td>
<td>Update on ‘atlas of variation’ in use of diagnostic tests in primary care, and likely similarities in acute care</td>
</tr>
<tr>
<td>iv.</td>
<td>Possibly invite to NCAS on their insight into unsafe practitioners</td>
</tr>
<tr>
<td>v.</td>
<td>Possible invite to NHSLA, focused on how CNST provides overall standards</td>
</tr>
</tbody>
</table>

**Next Meeting**

Next Meeting:

11:00-13:00 Thursday 5<sup>th</sup> December  
NHS England, Room 7, 4-8 Maple Street, London, W1T 5HD

*For those members who also attend the RCP Patient Safety Committee meeting, please note it is booked for the afternoon that day; details will be sent out by the RCP*

Dates for 2014 will be set as soon as possible.