

NHS England

Summary of Minutes of the Patient Safety Steering Group held In Maple Street on Monday 13th January 2014

Present

- Mike Durkin – Director of Patient Safety, NHS England (Chair)
- Martyn Diaper – Clinical Director, South East Hampshire Integrated Service Division Southern Health NHS Foundation Trust and Chair Primary Care Patient Safety Expert Group
- Matt Fagg – Deputy Director, Reducing Mortality, NHS England
- Paul Farmer – Chief Executive Officer MIND and Chair Mental Health Patient Safety Expert Group
- Tim Hillard – Consultant Gynaecologist, Poole Hospital and Chair Women's Health Patient Safety Expert Group
- John Stewart, Director of Quality Framework, NHS England
- Martin McShane, Director of Long Term Conditions, NHS England
- Karen Middleton – Chief Allied Healthcare Professional, NHS England
- Neena Modi (via TC) – Vice President, Science and Research, Royal College Paediatrics and Child Health and Chair Children and Young People Patient Safety Expert Group
- Juliette Beal, Director of Nursing, NHS England
- Linda Patterson, Immediate past Vice President, Royal College of Physicians and Chair Medical Specialties Patient Safety Expert Group
- Norman Williams – President Royal College of Surgeons and Chair Surgical Services Patient Safety Expert Group
- Josephine Ocloo, Patients and Public Representative
- Cate Quinn, CQC

Apologies

- Neil Churchill – Director, Patient Experience, NHS England
- Gill Harris – Regional Director of Nursing, North, NHS England
- Julie Harries – Head of Programme for Safety, NHS IQ
- Richard Jeavons, Director NHS IQ
- Andy Mitchell – Medical Director, London Region, NHS England
- Keith Willett – Director, Acute Episodes of Care, NHS England
- Suzanne Shale, Ethics Advisor
- Celia Ingram-Clarke, NHS Director of Premature Mortality, NHS England
- Ann Sutton – Director of Commissioning (Corporate), NHS England
- Sarah Pinto – Duschinsky, Regional Director of Operations and Delivery, NHS England
- Sue Hill, Chief Scientific Officer, NHS England

In attendance

- Joan Russell – Head of Patient Safety, NHS England
- Bruce Warner – Deputy Director of Patient Safety, NHS England
- Paola Brolis – Admin Support Manager, NHS England (Minutes)
- David Cousins – Head of Patient Safety, NHS England
- Fiona Carragher – Deputy Chief Scientific Officer, NHS England (Deputy for Sue Hill)
- Richard Fluck – National Clinical Director for Renal Services

Item	
1	Welcome, introductions and declarations of interest in matters arising on the agenda
1.1	The Chair welcomed everyone to the meeting and introductions were made. The Chair introduced Josephine Ocloo, appointed to be Patients and Public Representative for NHS England and co-chair from the next meeting.
1.2	Two points of clarity were raised from the minutes of the last meeting.
2	Draft Patient Safety Alerts
2.1	Improving medication error incident reporting and learning <p>David Cousins gave a presentation focusing on the aim of these two draft Patient Safety Alerts. Both Alerts describe a joint initiative with the Medicines and Healthcare Regulatory Authority (MHRA) to improve the numbers and quality of incidents reported to the National Reporting and Learning System (NRLS) related to medical devices and medication error. The Patient Safety Alerts also recognise the need for improving learning from incident reporting at local and national level.</p>
2.2	<p>Key recommendations in both Patient Safety Alerts are to:</p> <ul style="list-style-type: none"> • Ensure oversight from a Board Level Director • Identify a Medication Safety Officer and Medical Devices Safety Officer • Identify a new or existing multidisciplinary group to review incident reports and improve reporting and learning
2.3	<p>Both Patient Safety Alerts have been through wide stakeholder consultation and have, overall, received wide support. Further clarification was sought on the impact on the Independent Sector, Community Pharmacy and Primary Care as well as the role of CCG's and Area Teams.</p>

2.4	<p>Feedback and questions received from the Patient Safety Steering Group included:</p> <ul style="list-style-type: none"> • What NHS England intended to do with the additional reports received • Whether NHS England has the capacity to manage all the reports received • What approach should be taken when the patient safety issues relate to the way the device is being used • What is the patient's role in reporting
2.5	<p>The Chair and David Cousins responded by describing the current processes for interrogating the NRLS, the new Patient Safety Alert system and recognising the need to work more smartly with the NHS. Bruce Warner explained the process for clinical review of data to explain how an increased volume of reports would be managed.</p>
2.6	<p>The Chair asked the group for broad support on these two alerts subject to further changes as discussed and agreement for sign off by the Chair before the next meeting. The Patient Safety Steering Group agreed. The final versions will be circulated for information.</p> <p>Non-Luer Spinal (Intrathecal) Devices for Chemotherapy and Lumbar Puncture</p>
2.7	<p>David Cousins gave another presentation to provide the background for the need for a third Patient Safety Alert on non-luer spinal devices. A full range of devices is now available for use in intrathecal chemotherapy but further devices are still required for other procedures.</p>
2.8	<p>The Chair asked the group for broad support on this alert subject to further changes as discussed and agreement for sign off by the Chair before the next meeting. The Patient Safety Steering Group agreed. The final versions will be circulated for information.</p>
Action 1	<p>NHS England to recirculate the three Patient Safety Alerts for information prior to issue.</p>
3	<p>Oversight of Specialist Groups</p>
3.1	<p>Small Bore Connector Device Clinical Advisory Group</p> <p>This group is being established to provide advice to NHS England on the safe introduction of a range of new 'Non-Luer' connector designs in medical devices in the future.</p>
3.2	<p>It was proposed for this new group to report to the NHS Patient Safety Expert Groups and the Patient Safety Steering Group. This proposal and the Terms of Reference for the new group were agreed.</p>

4	Acute Kidney Injury (AKI) Programme Board
4.1	Richard Fluck provided an update of the AKI Programme following a brief overview provided at the last meeting. It was emphasised that AKI is not a specialty specific issue and the majority of cases arise in the community and in hospital wards across medicine and surgery. The programme of work is scheduled for three years.
4.2	A number of work streams to feed into the programme have also now been established with chairs and co-chairs appointed.
4.3	Three emerging issues from the recent AKI Programme board meeting were raised: <ul style="list-style-type: none"> • The need to agree a national definition for AKI – a proposal will be brought to the Patient Safety Steering Group • Whether the Programme can include a measurable ambition of improvement • Several of the work streams leads are not being supported for release by their own organisations without financial remuneration
4.4	Feedback from the Patient Safety Steering Group included recognition that there was opportunity for this programme to engage with other work programmes in NHS England and that that the issue of remuneration had wider implications than solely patient safety or AKI.
Action 2	Richard Fluck to share a paper on national definition for AKI at next meeting.
Action 3	Chair and Martin McShane to discuss the issue of remuneration with National Directors
5	Points of clarity from briefings
5.1	The Chair and members of the Patient Safety Steering Group had no points of clarity to discuss.
6	Draft Report from Surgical Never Events Taskforce
6.1	Norman Williams introduced this item by informing the Patient Safety Steering Group that the number of reported Surgical Never Events is still significant. As Never Events should be preventable, the Taskforce was commissioned to identify alternative ways to reduce their occurrence in addition to the already existing Surgical Safety Checklist. Data show that full implementation of the Checklist together with brief and debrief has not yet been achieved across the NHS.
6.2	Key elements of the Taskforce report to be considered are: <ul style="list-style-type: none"> • The development of National Standards as the basis for standardised local procedures • A system wide approach to education and implementation • The establishment of a Surgical Serious Incident Investigation Unit

6.3	The report from the Surgical Never Events Taskforce will be published by the end of February 2014.
6.4	The next phase will be for NHS England to develop an implementation plan in collaboration with the Surgical Services Patient Safety Expert Group.
6.5	The Chair informed the group that implementation of the Surgical Never Events Taskforce report will be linked to the regular publications of Never Events, which from April will become monthly.
6.6	<p>Feedback and queries from the Patient Safety Steering Group included:</p> <ul style="list-style-type: none"> • How do recommendations from the Taskforce relate to the Duty of Candour and access to mental health services? • The Royal College of Physicians have undertaken work on staff being the second victim of serious incidents • The importance of the patient's perspective when agreeing guidance on the Duty of Candour
Action 4	Joan Russell to review task force report to clarify that any recommendations around support for the victim reflect the outcome of the work being led by Norman Williams
7	Issues from Mental Health Patient Safety Expert Group
7.1	<p>National Reporting and Learning System</p> <p>Paul Farmer gave a presentation on the challenges that the Mental Health Patient Safety Expert Group is experiencing with interpreting the NRLS data due to issues with quality. He summarised that although the quality of a lot of the data is good issues include:</p> <ul style="list-style-type: none"> • Inadequate incident descriptions • Inaccuracy around the reporting of deaths and severe incidents • Confusion around safeguarding and abuse reporting
7.2	Paul farmer asked whether a collective approach should be taken to improving the data quality.
7.3	Bruce Warner reported initiatives to improve NRLS data quality are in place and the quality of data is of concern across the patient safety domain, as evidenced by the need for the medication and medical devices alerts discussed earlier.
7.4	It was reflected that the NHS England Parity of Esteem work stream was dependent on mental health intelligence so the need for quality data could be raised in this forum.
7.5	It was also reflected that further work needed to be done to ensure that patients and carers can raise their concerns through reporting and also to work with the press to ensure that appropriate information goes out to support data when made public.

<p>7.6</p> <p>7.7</p>	<p>Duty of Candour</p> <p>Paul Farmer discussed the application of the Duty of Candour in the Mental Health Sector with special focus on:</p> <ul style="list-style-type: none"> • Timeliness of the conversation to have with a mental health patient • High quality communication : training and support is required for staff as a specific skill set is required for staff to discuss incidents with a patient • Honesty: the mental impact of a conversation with a patient is underestimated <p>Norman Williams informed the Patient Safety Steering Group of the 'Dalton and Williams Review of the Duty of Candour commissioned by the Secretary of State' and requested that Paul Farmer provide him with an overview of the potential for psychological harm.</p>
<p>Actions 5</p> <p>Action 6</p>	<p>Paul Farmer to share views on psychological harm with Norman Williams within the next month</p> <p>All Chairs to provide a summary of each Patient Safety Expert Groups views on Duty of Candour to Norman Williams</p>
<p>8</p> <p>8.1</p> <p>8.2</p>	<p>Any Other Business</p> <p>All presentations will be sent out after the meeting to members of the Patient Safety Steering Group.</p> <p>The Chair requested that we receive some agenda items from Chairs of Patient Safety Expert Groups as well as briefs at the next meeting</p> <p>No additional items of business were raised.</p>
<p>Date of next meeting</p>	<p>6th March 2pm – 4:30pm</p>

Signed: _____ Dr Mike Durkin

Dated: _____