NHS England

Summary of Minutes of the Patient Safety Steering Group held In Maple Street on 21 October 2013

Present

- Mike Durkin – Director of Patient Safety (Chair)
- Neil Churchill – Director, Patient Experience
- 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
- Paul Farmer – Chief Executive Officer MIND and Chair Mental Health Patient Safety Expert Group
- Julie Harries – Head of Programme for Safety, NHS IQ
- Gill Harris – Regional Director of Nursing, North
- Tim Hillard – Consultant Gynaecologist, Poole Hospital and Chair Women’s Health Patient Safety Expert Group
- Bill Kilvington – President College of Operating Department Practitioners, Deputising for Norman Williams, Chair Surgical Services Patient Safety Expert Group
- Andy Mitchell – Medical Director, London Region
- Ed Mitchell – Deputising for Martin McShane, Director of Long Term Conditions
- Karen Middleton – Chief Allied Healthcare Professional
- Neena Modi – Vice President, Science and Research, Royal College Paediatrics and Child Health and Chair Children and Young People Patient Safety Expert Group
- Keith Willett – Director, Acute Episodes of Care
- Tim Young – Head of NHS Operations

Apologies

- Linda Patterson, Immediate past Vice President, Royal College of Physicians and Chair Medical Specialties Patient Safety Expert Group
- Juliette Beal, Director of Nursing, NHS England
- Richard Jeavons – Managing Director, NHS IQ
- Martin McShane – Director, London Term Conditions
- Ann Sutton – Director of Commissioning (Corporate)
- Norman Williams – President Royal College of Surgeons and Chair Surgical Services Patient Safety Expert Group
- John Stewart – Director, Quality Framework

In attendance

- Joan Russell – Head of Patient Safety, NHS England
- Bruce Warner – Deputy Director of Patient Safety, NHS England
- Daniel Eghan – Patient Safety Accountability Manager, NHS England (Minutes)
- Salman Gauher – Clinical Fellow, Reducing Mortality (Observer)
<table>
<thead>
<tr>
<th>Item</th>
<th>Welcome, introductions and declarations of interest in matters arising on the agenda</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>The Chair welcomed everyone to the meeting and introductions were made. Neena Modi and Martyn Diaper both made declarations of interest.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2</th>
<th>Terms of Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.2</td>
<td>The Chair clarified that the Patient Safety Steering Group has accountability to the NHS England Executive Team who will receive regular reports from these meetings. It was noted that the Patient Safety Steering Group would issue an annual report and that minutes would be available on the NHS England website.</td>
</tr>
<tr>
<td>2.3</td>
<td>It was suggested that patient representation on both the Patient Safety Steering Group and Patient Safety Expert Groups needed to be strengthened and that a patient co-chair would create further transparency and demonstrate commitment for true patient participation.</td>
</tr>
<tr>
<td>2.4</td>
<td>The Chair asked whether membership of the Patient Safety Steering Group was appropriate and if any additional representation was required. It was proposed that the Care Quality Commission (CQC) Medicines Healthcare Products Regulatory Agency and Health Education England (HEE) should have representation.</td>
</tr>
<tr>
<td>2.5</td>
<td>A query was raised over the current robustness of the National Reporting and Learning System (NRLS) in capturing patient safety incident reports from staff and patients. It was pointed out that a large piece of work was being carried out on reviewing future requirements for the NRLS. This work includes improving reporting in primary care as well as from patients.</td>
</tr>
<tr>
<td>2.6</td>
<td>It was noted that the medical curriculum needed to add patient safety into the education of students and closer links needed to be established with Health Education England (HEE).</td>
</tr>
<tr>
<td>2.7</td>
<td>The Chair concluded by asking members to send any further reflections on Terms of Reference to the secretariat.</td>
</tr>
</tbody>
</table>

<p>| Actions 2a | NHS England to consider recruiting additional membership from the CQC, Medicines Healthcare Products Regulatory Agency and HEE for the Patient Safety Steering Group. |
| 2b | NHS England to consider a patient representative co-chair for Patient Safety Steering Group. |
| 2c | Chair asked members to send any further reflections on the Terms of Reference to the secretariat. |</p>
<table>
<thead>
<tr>
<th>3</th>
<th><strong>Patient Safety Expert Group Feedback</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Children and Young People</strong></td>
<td>Neena Modi (Chair of Children and Young People Patient Safety Expert Group) provided an update on the current priorities of this group.</td>
</tr>
</tbody>
</table>
| 3.1 | The main priorities that have been agreed by the Patient Safety Expert Group are;  
- Fragmentation of care during the interface from infants to children and from children to adults.  
- Supporting the ‘Improving medicines use in children and young adults’ project.  
- Improving the quality of data reported to the NRLS for children.  
- To support the Children’s and Young People’s Patient Safety Implementation plan and national agenda. |
| 3.3 | The Patient Safety Expert Group has also expressed concern that “The British National Formulary for Children” has not received accreditation from the National Institute for Clinical Excellence. This is being followed up with the Royal College of Paediatrics and Child Health. |
| 3.4 | The importance of using the information from Children’s intelligence networks was also agreed as a key way forward. |
| **Medical Specialties** | Joan Russell gave an update on the progress of the Patient Safety Expert Group in Linda Patterson’s absence. Early priority areas for the group based on NRLS death and severe harm in medical specialties and the PRISM mortality research include;  
- Safer invasive procedure checklist  
- Falls and pressure ulcers because of the scale of harm  
- Diagnostic error, potentially linked to “right test at the right time”  
- Protecting patients against allergies  
- Surviving sepsis  
- Access to records and good record keeping (paper and electronic)  
- Breaking down boundaries between primary and acute care  
- Reservist force- resource for wards/ units spiralling into failure  
- Support/ endorse underlying standards of patient safety for all medical specialities |
| **Mental Health** | Paul Farmer (Chair of Mental Health Patient Safety Expert Group) gave an update on the work of this group. |
| 3.6 | The Patient Safety Expert Group is currently prioritising their work and immediate questions have been raised on data management and how they can ensure they have access to high quality data. The Patient Safety Expert |
Group is looking at the development of the safety thermometer, reactive and proactive reports on restraint in mental health and how patient and public involvement in reporting could be improved. The Patient Safety Expert Group is also interested in resources, bed occupancy, suicides in mental health and is interested in working collaboratively with other Patient Safety Expert Groups on issues around Parity of Esteem.

Suggestions were made for future priorities in mental health and it was reflected that other work programmes in mental health are already in place in NHS England including work on Parity of Esteem and physical health in mental health. The role of the Information Centre could also be explored in more effectively utilising available data.

Paul Farmer expressed some concern over how Patient Safety in mental health will be resourced.

**Primary Care**

Martyn Diaper (Chair of Primary Care Patient Safety Expert Group) reflected that it has been agreed that the group’s priorities should initially focus on General Practice. As General Practitioner (GP) engagement develops then the remit will extend more widely into others areas of primary care.

Martyn Diaper agreed that wider membership would also be useful as the remit of the Patient Safety Expert Group expanded.

The issues identified by the Patient Safety Expert Group so far are;

- Engaging GP’s in incident reporting and understanding current barriers.
- Addressing the safety culture in primary care.
- Current legislation around dispensing error
- Communication of pathology test results out of hours
- Safer discharge from acute to primary care
- Need to support the wider NHS England Primary Care Strategy
- The need to develop a communications strategy for the Patient Safety Expert Group

Martyn Diaper also asked for clarity over when the Patient Safety Expert Group needed to seek approval from the Steering Group. The Chair responded that he would like to empower the Patient Safety Expert Groups to take their own lead where they see appropriate.

**Surgical Services**

Bill Kilvington gave an update on this Patient Safety Expert Group on behalf of the Chair, President of the Royal College of Surgeons (RCS).

The Patient Safety Expert Group has recognised the need to measure its impact and also how it can promote learning from NRLS data.

Current priorities for the Expert Group are;
3.17 Ownership and implementation of the recommendations from the Surgical Never Events Task Force, Management of blood sugar in surgical patients, Deterioration and failure to rescue, Surgical care of the elderly, Management of pre-operative fasting, Training and development for the perioperative team.

Bill Kilvington stressed the importance of human factors in how teams work together in safe perioperative care and that this had been a key consideration of the Taskforce.

3.18 Women’s Health

Tim Hillard (Chair of the Women’s Health Patient Safety Expert Group) reported that this Patient Safety Expert Group would meet for the first time in December 2013 in shadow format. Membership will comprise the existing Royal College of Obstetricians and Gynaecologists (RCOG) Quality and Safety Committee and be expanded to cover all aspects of Women’s Health. Core membership will also be consistent with the other Patient Safety Expert Groups.

Joint letters of invite are currently being sent out from NHS England and the RCOG.

An overall reflection by the Chair was that it would be useful to have a communications lead identified for each Patient Safety Expert Group in order to support the development of a communication strategy.

The Chair thanked all the Patient Safety Expert Group chairs for their helpful updates and reflected that any ideas on improvements to the NRLS, to support their remit for utilisation of data, would be welcome as part of the current review.

<table>
<thead>
<tr>
<th>Actions 3a</th>
<th>NHS England to consider the identification of communication support for each Patient Safety Expert Group.</th>
</tr>
</thead>
<tbody>
<tr>
<td>3b</td>
<td>Chair requested that any feedback on improvements to the NRLS, as part of the current review, should be channelled through the Patient Safety Expert Groups.</td>
</tr>
</tbody>
</table>

4 Future Production of Patient safety Alerts

4.1 Bruce Warner presented a paper on National Patient Safety Notifications, a new system of alerting the NHS to emergent patient safety risk, that allows timely dissemination of relevant safety information to providers, as well as acting as an educational and implementation resource.

4.2 The types of notifications that would be covered are new or under recognised patient risks, widespread, common and challenging patient safety issues and improving systems for clinical governance, reporting and learning.

4.3 Notifications would be disseminated via the Central Alerting System (CAS). The process of notification development would be NICE evidence accredited.
4.4 Wide stakeholder consultation is currently taking place.

4.5 Notification development would be sponsored wherever possible by the relevant Patient Safety Expert Group and signed off by the Patient Safety Steering Group.

4.6 The Patient Safety Steering Group considered the paper and agreed to ratify the proposal and suggested that Social media be used to promote the system.

4.7 The paper ultimately needs to be signed off by the Executive team.

4.8 The Chair thanked Bruce Warner for the work done on this proposal.

<table>
<thead>
<tr>
<th>Action 4a</th>
<th>NHS England to raise awareness of the Notification system through Social Media</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td><strong>Acute Kidney Injury (AKI) Programme Board</strong></td>
</tr>
</tbody>
</table>

5.1 Joan Russell gave an update on the establishment of the AKI Programme Board on behalf of Richard Fluck, NCD for Renal Services, who is chair of the Board. This is a joint initiative with the Renal Registry.

5.2 Evidence shows that it is estimated that 1 in 5 emergency admissions into hospitals are associated with AKI (Selby et al), that up to 1,000,000 deaths in secondary care are associated with AKI and that ¼ to 1/3 have the potential to be prevented (NCEPOD Adding insult to injury 2009).

5.3 The primary aim of the AKI board is to deliver and implement a structure and tools within 3 years that will lead to fall in the number of preventable episodes of AKI and with that that a reduction in deaths associated with AKI.

Objectives include:

- Ensuring that a variety of tools and interventions are developed and implemented to support the prevention, early detection, treatment and enhanced recovery of patients with AKI.
- Ensuring that patients who develop AKI are appropriately managed to reduce further deterioration, long term disability and death.
- Ensuring that appropriate education and training programmes are developed for all health professionals based on best available evidence.
- Ensuring that commissioners, health care professionals and managers are aware of the importance and risks of AKI and appropriate local strategies to reduce the burden of AKI are developed.
- Developing a national registry and audit for AKI leading to an improvement strategy on a national and local basis to reduce unwarranted variation in care.
- Involving patients and the public in understanding the risk of AKI and preventative measures through education and appropriate access to personal information.

The Patient Safety Steering Group welcomed the establishment of this Board.
5.4 and is keen to support its on-going work in this area.

6 Venous Thromboembolism (VTE) Programme Board

6.1 The Chair gave an update to the Patient Safety Steering Group and explained that the responsibility for the National VTE Programme has now come into NHS England. A presentation summarised the history of the National VTE Prevention Programme, success to date, current challenges and priorities moving forward.

6.2 As background, the Health Select Committee Report in 2005 concluded that there was “no systematic approach to identifying and treating patients at risk from VTE in hospitals” and that there was “significant room for improvement.” Since then, progress has been made through the collaboration of clinical experts, NHS leaders and dedicated health professionals with the aim of ensuring that VTE prevention strategies are fully integrated into NHS systems and processes.

6.3 An ambitious phase of National VTE Prevention Programme implementation began in 2010 with the introduction of a number of system measures that have driven success to date.

Some examples of the successes were:

- Mandatory collection of VTE risk assessment data linked to National CQUIN & supported by Information Standard
- % patients risk assessed for VTE on admission to hospital stands at average of 96% nationally, compared with <45% in June 2010
- VTE Exemplar Centres Network provide leadership in VTE prevention and promotes best practice by bridging national strategy and local implementation to drive forward improvements in clinical quality
- Establishment of the VTE ‘4 Professions Group’, bringing together the Royal College of Surgeons, the Academy of Medical Royal Colleges, the Royal College of Nursing, the Royal College of Midwives and the Royal Pharmaceutical Society to provide professional leadership for VTE prevention

6.4 The Steering Group agreed their role in providing accountability to the Programme Board and approved the revised terms of reference.

7 Patient Representation

7.1 Joan Russell described the process of recruiting representatives onto the Patient Safety Steering Group and Patient Safety Expert Groups. Two will be recruited to the Patient Safety Steering Group by interview and one to each of the Patient Safety Expert Groups through a selection process. Each Patient Safety Expert Group already has a representative from Action Against Medical Accidents (AvMA).

The Patient Safety Steering Group approved the process but also asked for a co-chair to be appointed to the Patient Safety Steering Group.

**Actions 7a** NHS England to advertise for patient representatives and recruit to the Patient Safety Steering Group and each of the Patient Safety Expert Groups.
<table>
<thead>
<tr>
<th></th>
<th>Any Other Business</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.1</td>
<td>All presentations will be sent out after the meeting to members of the Patient Safety Steering Group. No additional items of business were raised.</td>
</tr>
</tbody>
</table>

**Date of next meeting**  13th January 2014 – 14.30-16.30

Signed: ________________________________ Dr Mike Durkin

Dated: ________________________________