

NHS England

Summary of Minutes of the Patient Safety Steering Group held at Skipton House on Monday 20th October 2014

Present

- Mike Durkin – Chair, Director of Patient Safety, NHS England (absent for first half of meeting)
- 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
- Clare Marx – President, Royal College of Surgeons and Chair Surgical Services Patient Safety Expert Group
- Juliet Beal – Director of Nursing, NHS England
- Suzette Woodward – Director, Sign Up to Safety Campaign
- Steve Fairman – Director, NHS IQ
- Celia Ingham Clark – National Director of Reducing Premature Mortality, NHS England
- Tim Hillard – Consultant Gynaecologist, Poole Hospital and Chair Women's Health Patient Safety Expert Group
- Fiona Thow – Patient Safety Collaborative Delivery Lead, NHS IQ
- Andy Mitchell – Regional Medical Director (London Region), NHS England
- Roopen Arya – Director of Thrombosis, King's College Hospital
- Paula Mansell – Themed Inspection Manager, CQC
- Shelagh Morris – Deputy Chief Health Allied Health Professions Officer, NHS

Apologies

- Josephine Ocloo – Lead for Developing Patient Safety Champions Network, Imperial College London (Co-Chair)
- Charlotte Augst – Voluntary Sector Representative
- Suzanne Shale - Ethics Advisor
- Mike Davis - Patients and Public Representative
- Paul Farmer – Chief Executive Officer MIND and Chair Mental Health Patient Safety Expert Group
- Martin McShane - Director of Long Term Conditions, NHS England
- Lisa Hughes – Associate Director, Education and Quality
- Neil Churchill – Director of Patient Experience, NHS England
- Neena Modi – Vice President, Science and Research, Royal College Paediatrics and Child Health and Chair Children and Young People Patient Safety Expert Group
- Sue Hill – Chief Scientific Officer, NHS England
- Bruce Warner – Deputy Chief Pharmaceutical Officer, NHS England
- Keith Willett – Director, Acute Episodes of Care, NHS England
- John Stewart – Director of Quality Framework, NHS England
- Gill Harris - Nursing Director North Region, NHS England

In attendance

- Joan Russell – Head of Patient Safety, NHS England
- Hannah Thompson – Team Coordinator, NHS England (Minutes)
- Jane Blower – Deputy Chief Scientific Officer, NHS England (on behalf of Sue Hill)
- David McNally – Deputy Director Patient Experience, NHS England (on behalf of Neil Churchill)
- Heather Payne – Consultant in Paediatrics, Welsh Government (on behalf of Neena Modi)
- Dagmar Luettel – Patient Safety Lead Medical Devices, NHS England
- David Gerrett – Senior Pharmacist, NHS England
- Richard Fluck – National Clinical Director for Renal

<p>Item A</p>	<p>Welcome and Introduction</p> <p>Joan Russell gave apologies on behalf of Mike Durkin that he was unable to be there for the first half of the meeting. Martyn Diaper had agreed to act as Chair for the first part of this meeting.</p> <p>Martyn Diaper welcomed everyone to the meeting and introductions were made.</p> <p>Declarations of interest were sought and none were raised.</p>
<p>Item B</p>	<p>Minutes from last meeting</p> <p>The following feedback was received:</p> <ul style="list-style-type: none"> • Shelagh Morris was not present at the last meeting and had sent apologies • Under item H MEWS should more accurately be NEWS <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 6 Joan Russell provided feedback that DH is in the process of procuring some resources to support the introduction of the Duty of Candour. The Patient Safety Steering Group will be kept informed of the procurement process</p> <p>Action 6 Paul Farmer sent his apologies for the meeting so it was agreed that his action 'to identify a short list of priorities for Patient Safety Expert Groups to consider' should be carried forward to the next meeting</p> <p>Action 8 Joan Russell has met with the lead for the work on discharge at Health Watch England and has invited her to present the findings of the study at the next meeting</p> <p>Action 9 Lisa Hughes sent apologies for the meeting so the action for Health Education England to explore opportunities for inclusion of 'escalation' in training programmes and feedback will be carried forward to the next meeting</p>

	All other actions were either on the agenda or closed.
Item C	<p>Points of clarity from briefings</p> <p>The briefings below were further clarified:</p> <p>Medical Specialities Patient Safety Expert Group (PSEG)</p> <p>Linda Patterson explained that there was a discussion on differences in nomenclature of laboratory test results. Linda Patterson was informed that this work relates to the Medicines Map initiated by the Department of Health, but does not sit anywhere at present. It was suggested that she contacts National Clinical Director for Pathology for further support.</p> <p>Linda Patterson also suggested that approaches should be developed to managing knowledge in a timely way in Patient Safety Expert Groups. It was agreed that the levers paper recently produced for the Patient Safety Expert Groups should be recirculated.</p> <p>It was suggested that a presentation on behavioural change would be useful at a future meeting</p> <p>Primary Care PSEG</p> <p>Martyn Diaper briefly expanded on the planned work to develop a checklist for outstanding tests as part of the work programme relating to handover at discharge. The timescale for actions relating to the Patient Safety Alert has now passed.</p> <p>Surgical Services PSEG</p> <p>Clare Marx highlighted issues relating to recognised conditions requiring emergency surgery and surgical complications in patients with previous solid organ transplants. It was agreed that these types of issues are not appropriate for Patient Safety Alerts. The Patient Safety Steering Group agreed that there is an issue across the board over lack of education on patient safety and there is a need for standard patient safety questions in exams. The Patient Safety Steering Group agreed that this view should be expressed to the General Medical Council (GMC), Nursing and Midwifery Council.(NMC) and General Dental Council (GDC)</p> <p>A presentation had been given on work undertaken to reduce the risk of wrong tooth extraction, which included standardised nomenclature and checks. It was proposed that there is a need for a national approach to standardising teeth nomenclature</p> <p>Locum issues remain an issue throughout the NHS including concerns that, locums are not properly screened, and do not receive effective induction. It was recognised that this was more of an issue for NHS Employers.</p> <p>Venous Thrombo Embolism (VTE)</p> <p>Roopen Arya explained that there has been a 9% reduction in mortality from VTE due to the use of prophylaxis. A query was raised as to whether this</p>

	<p>was due to prophylaxis or the whole education programme. It was clarified that the CQUIN for VTE has increased staff awareness as well as reducing readmission rates due to bleeding complications.</p> <p>The VTE Programme Board is currently receiving a large number of queries over the Duty of Candour.</p> <p>Women’s Health PSEG</p> <p>Tim Hilliard added that the RCOG are embedding risks of harm in patients in surgery on patients with solid organ transplants into the core curriculum. The PSEG had received a presentation on still births as part of the launch of ‘Each baby counts’.</p> <p>Children and Young People’s PSEG</p> <p>Heather Payne informed the Patient Safety Steering Group that there is currently a working group being led by Jackie Cornish, National Clinical Director for Transition, to address the issues of e-prescribing for oncology in children. There is ongoing work with the NRLS to address the lack of specific data for children and young people.</p>
<p>Action 1</p>	<p>Joan Russell to recirculate ‘Levers for influencing patient safety’ with minutes from the meeting</p>
<p>Action 2</p>	<p>Letters to be written from Chair of Patient Safety Steering Group to Chief Executives of GMC, NMC and GDC with regards to inclusion of patient safety in examination questions</p>
<p>Item D</p>	<p>Acute Kidney Injury (AKI) Programme</p> <p>Richard Fluck gave a presentation to update the group on the AKI programme. The programme is a 3 year plan to:</p> <ol style="list-style-type: none"> 1. Establish the data flows to allow successful audit and quality improvement 2. Provide clinicians and patients with the education, information and access to and about AKI to inform individual care 3. Support commissioners and organisational leads in driving and championing the need to improve AKI care <p>Richard Fluck shared with the group recent media articles on AKI where it is stated that 40,000 patients die annually due to failure to diagnose treatable kidney problems. He shared the structure of the programme structure, which included education, risk, detection, treatment, measurement and commissioning.</p> <p>A stage three alert was released on the 9th June 2014 for standardising the early identification of Acute Kidney Injury, which outlined five actions which each acute trust and foundation trust need to complete relating to the introduction and use of the AKI Algorithm. The concern since has been raised about what to do in Primary Care with regards to notification of when patients are detected with AKI as staff in primary care need to be supported by further training and resources to interpret test results and manage patients with AKI.</p>

	<p>Richard Fluck also shared that the programme will focus on providing resources to secondary care and educating primary care in 2015 with resources then being provided for primary care in 2016.</p> <p>A website has now been developed for the AKI programme and ‘think kidney’ has been agreed for branding purposes.</p> <p>A national CQUIN is currently being considered by NHS England which will focus on improving the reporting of AKI in discharge summaries and educating GPs.</p> <p>A member of the group raised a question regarding end of life care and whether these people will be included in the AKI programme. RF responded that blood tests wouldn’t normally be carried out on those patients so they won’t be included in the programme.</p> <p>It was reported that many sites who have already ‘Signed up to Safety’ are interested in including AKI in improvement plans.</p>
Action 3	Richard Fluck to liaise with Suzette Woodward over inclusion of AKI in the Sign up to Safety campaign
Item E	<p>Draft Patient Safety Alerts for Approval</p> <p>Minimising risks arising from unavailable medical devices</p> <p>Dagmar Luettel asked the group for feedback and approval for this draft Alert. The proposal for this Alert has risen as 37% of incidents involving medical devices/equipment reported to the NRLS are because of unavailability or lack of devices and equipment. Review of NRLS data identified that most incidents identified issues with systems as causal factors.</p> <p>From incidents reviewed</p> <ul style="list-style-type: none"> • 23% were relating to unavailable beds and mattresses • 11% involved surgical instruments • 4% involved electronic infusion devices • 29% was reported as other <p>A number of concerns were raised about the focus of the Alert and whether the scope was too big. A number of suggestions were made:</p> <ul style="list-style-type: none"> • Actions should include that trusts review their own data relating to medical devices to identify local issues • Input should be sought from Directors of Facilities and Estates • The Alert should clarify whether infants are also occurring with children • Actions should include audit of local protocols to identify where these are failing • <p>The group concluded that the focus of the alert and its target audience should be reviewed and then resubmitted to the Patient Safety Steering Group.</p>
Action 5	Dagmar Luettel to revise the Alert according to the group’s recommendations and resubmit to the Patient Safety Steering Group

	for approval.
	<p>Appropriate dosing of Naloxone David Gerrett briefed the group that death and harm has occurred where this drug has been prescribed inappropriately, as there are complicated dosing ratios with this drug, which not all clinicians may know about. The aim of this Alert is to raise the awareness of the potential harm of Naloxone, rather than change the guidance.</p> <p>The Patient Safety Steering Group questioned the importance of this Alert as there are only a few cases where severe harm or death have occurred. David Gerrett clarified that although there are only three cases of severe harm identified, other incidents have also occurred.</p> <p>It was agreed that an Alert would be worthwhile as there was a significant risk of further incidents occurring since the issues relating to dosing are not well known. It is important that the Alert reflects the requirement to make sure that hospitals are giving guidance and training on the use of this drug.</p>
Action 6	David Gerrett to include more detail on numbers of incidents in the Alert and whether any children were harmed because of Naloxone
Action 7	David Gerrett to revise the Alert in accordance with other feedback and email to the Patient Safety Steering Group for final approval
	<p>Failure to act on contraindications for Low Molecular Weight Heparins (LMWH)</p> <p>David Gerrett explained to the group that there are 2,000 to 3,000 cases a year of harm, which is related to contraindications for LMWH. This problem has occurred because of health professionals not using appropriate guidance for prescribing after undertaking risk assessment. The challenge of this Alert is to bring down the rate that this drug is being inappropriately prescribed.</p> <p>A more detailed breakdown of incidents was requested in relation to:</p> <ul style="list-style-type: none"> • Prescribing to those already on anticoagulants • Prescribing to those already bleeding • Incidents relating to treatment • Whether there was any data relating to children and maternity <p>It was agreed that in the longer term electronic prescribing is the way forward.</p> <p>The Patient Safety Steering Group agreed that the Alert is appropriate so that people are more aware of good use of LMWH and of the side effects. The Patient Safety Steering Group are happy for this to go out, but it needs careful rewording.</p> <p>It was also agreed that the Alert should include an additional balancing sentence recognising the benefits of anticoagulation and linking to the VTE programme.</p> <p>It was agreed that it would be useful to write this up a case study for</p>

	publication in collaboration with the VTE programme.
Action 8	David Gerrett to provide a more detailed breakdown of the NRLS
Action 9	David Gerrett to recirculate the alert to the Patient Safety Steering Group via email before it is published
Action 10	David Gerrett, Roopen Arya and others as appropriate to write up as a case study
Item F	<p>Update on Sign Up to Safety</p> <p>Suzette Woodward updated the group on Sign up to Safety, a three year campaign which has the ambition to reduce avoidable harm by 50%. Sign up to Safety is being designed to align with a number of other initiatives including the Patient Safety Collaboratives, Patient Safety Fellows and Safe Teams and form a key element of the English Patient Safety Programme.</p> <p>Initial participation for organisations means to:</p> <ul style="list-style-type: none"> • Commit 5 pledges • Implement 1 personal safety improvement plan • Nominate 1 safety lead and 1 campaign volunteer • Align with Academic Health Science Network (AHSN) and Patient Safety Collaborative Programme <p>Individuals can also participate and initial involvement includes:</p> <ul style="list-style-type: none"> • Making a personal pledge • Implementing 1 personal safety improvement plan • Join the team and become a volunteer • Promote the campaign <p>There have been 110 trusts who have signed up so far. The campaign has intrinsic and extrinsic motivation factors and social media and patient partnership will be vital to success. A Strategy and Advisory Group has been established chaired by Sir David Dalton. A 90 day plan is in place which includes:</p> <ul style="list-style-type: none"> • Launch call for experts to support improvement – Nov 14 • Increased participation for 12 to 60 organisations – Dec 14 • Campaign strategy including measurement and evaluation completed and launched – Dec 14 • Launch call for volunteers – Jan 15 <p>It was queried as to how it will be possible to monitor if trusts are delivering on improvement plans and what the advantages of ‘signing up’ are if organisations are already committed to local activity. The relationship with CQC was also queried. It was clarified that the opportunity for buddying with others will be an opportunity arising from the campaign and that the introduction of measurement and evaluation also key to success.</p> <p>It was agreed that it would be useful for each PSEG to have a greater understanding of Sign up to Safety</p>
Action 11	PSEG chairs to contact Suzette Woodward to present at PSEGs

<p>Item G</p>	<p>Overview of Primary Care Programme</p> <p>Martyn Diaper gave a presentation on the primary care patient safety programme. Despite the fact that the majority of care in the NHS takes place in primary care and many patient safety incidents can occur here. GP reporting is historically low, and there are less report from GPs than any other health care setting. In order to increase reporting and create the opportunity for greater learning it has been recognised that the e-form used to report into the NRLS needs to be simplified. This programme of work is also considering other incentives for GPs that can result from reporting. These include:</p> <ul style="list-style-type: none"> • Linkage to Continual Professional Development • using e-forms to trigger Significant Event Analysis • Inclusion as part of evidence requirements for Care Quality Commission <p>It is planned for the e-form to be launched at a GP Patient Safety Action Day in February, which is a proposed event to raise the awareness of patient safety in general practice and engage GPs in the NHS England work programmes.</p> <p>Martyn Diaper shared some concerns that have been raised in relation to a Patient Safety Action Day and the GP e-form. There is some nervousness about the way that an action day may be perceived by the public with risk of patient concerns that GPs are unsafe as reporting of incidents may be misinterpreted.</p> <p>The Patient Safety Steering Group made the following suggestions:</p> <ul style="list-style-type: none"> • The action day could be linked in with Sign up to Safety • Greater understanding required over what constitutes a patient safety incident • Community services could be included in the action day • Practice managers, nurses and pharmacists should be directly involved who do not have alternative means to report incidents • Share stories where there have been improvements due to GP reporting
<p>Item H</p>	<p>Second Victim – feedback from PSEGs and next steps</p> <p>The chairs of the PSEGs fed back to the group that they all agreed that there needs to be some guidance on this subject, as to improve the psychological health of health care providers will improve the quality of care they give, and improve its safety.</p> <p>The group agreed that the term was wrong, needed a new name and they felt the term was too specific for every case. This is also linked with the Duty of Candour.</p> <p>Individuals we asked to share any other national resources that they were aware of that they think useful.</p>
<p>Action 12</p>	<p>Second Victim to be kept on the agenda and consideration given to NHS England coordinating or identifying an appropriate organisation to coordinate the production of a resource package</p>

Action 13	Representatives to forward any national resources to Joan Russell that they think useful
Item I	<p>Update on Never Events retained vaginal swabs</p> <p>Tim Hillard updated the group that a targeted survey will be circulated shortly to organisations where never events have occurred. This has been delayed due to difficulties accessing NHS LA data. The survey is designed to identify themes in underlying causes.</p> <p>Juliet Beal reported that a member of her team had previously developed a protocol for actions to be taken when a never event occurs and that it would be useful to consider promoting this as part of this work programme.</p> <p>Joan Russell clarified that this work should also feed into the Surgical Never Events Taskforce Reference Group.</p>
Item J	<p>Any other Business</p> <p>The Chair mentioned the launch of the Patient Safety Collaboratives, which was on the 14th October 2014 which has already reached 3.7 million people on Twitter.</p> <p>The Chair also mentioned the possible move of NRLS and the National Patient Safety Alerting System to the Care Quality Commission (CQC) from NHS England. A decision is expected by January 2015.</p> <p>More information was requested on the Safe Team. The Chair explained that this is planned to be a support team that will go to trusts that that need help. However there is an ongoing issue of funding for this work.</p> <p>Date of next meeting: Tuesday 20th January 2014 14:00- 16:30 at Skipton House room 136B;137B</p>

Signed: _____ Dr Mike Durkin

Dated: _____