

# Notes from NHS patient safety strategy oversight committee meeting – 4 February 2020

## Present

National Director for Patient Safety, NHSE/I  
CEO, West of England Academic Health Science Network  
Regional Chief Nurse and Senior responsible Officer for the patient safety syllabus  
National Medical Examiner  
Acting Joint Regional Chief Nurse and Clinical Quality Director, NHSE/I  
Deputy Medical Director of Primary Care, NHSE/I  
Patient safety partner  
Patient safety partner  
Patient safety partner

## In attendance

Deputy Director of Patient Safety (Policy and Strategy) NHSE/I  
Head of Patient Safety Policy and Partnerships, NHSE/I  
Deputy Director of Patient Safety (Insight) NHSE/I  
Head of Patient Safety Cross-system development NHSE/I  
Policy and programme lead, Medical Examiner system NHSE/I

## Apologies

Programme Director Clinical Improvement, NHSE/I  
Deputy Chief Nursing Officer, Safety and Innovation NHSE/I

## 1) SOC notes and actions from the last meeting

Following feedback from SOC, updated terms of reference and membership were circulated prior to this meeting.

**Action:** SOC members are invited to send further feedback on terms of reference and membership to the secretariat.

There was discussion about the membership and formality of regional patient safety boards. London region are planning to formalise their board, with terms of reference and explicit links to the five Sustainability and Transformation Partnerships in the region. A question was raised about how the Patient Safety Collaboratives would interact with regional patient safety boards, and there was a call for some degree of consistency in membership between the seven regions. There was also a question about the role and relationship of these boards with Quality Surveillance Groups (QSGs), and SOC were informed that the latest

development proposals for QSGs are due to be discussed by the National Quality Board later this month.

## **2) Overview of strategy implementation progress**

It was reported that three patient safety partners had been recruited to SOC – one extra than the requirement in the terms of reference. It was noted that all three were in attendance despite short notice, and they were thanked for their time.

The patient safety team had contributed to a number of national initiatives to ensure alignment with the strategy and joined-up working. The NHS standard contract update includes reference to patient safety specialists, National Patient safety Alerts, incident reporting and Medical Examiners. The People Plan leadership compact was reviewed. Strategy elements were embedded into National Long Term Planning, Operational Planning guidance and the annual funding and resource publication.

All the delivery leads for the strategy objectives are engaged in the oversight process, and planning has begun on the first annual strategy refresh.

A question was asked about how the strategy addresses health inequalities for those impacted disproportionately by safety incidents, and vulnerable groups/protected characteristics more broadly. Currently, the data to underpin work of this nature only exists in certain aspects of safety – for example the MBRRACE report into maternity and neonatal care. The implementation of the Patient Safety Incident Management System should enable NHSI/E to collect better data in relation to protected characteristics to help identify which groups of people may be more likely to experience safety incidents, and what type of incidents these are.

Status updates for specific objectives were provided:

- A draft patient safety partners framework has been produced and clearances are underway to enable consultation hopefully this month.
- The 2020/21 CQUIN for Anti-Microbial Resistance has been confirmed, and a gram negative bloodstream infection target is included in the draft NHS standard contract.
- Regarding the objective to monitor the development of safety culture, the patient safety team had received the raw data from the NHS staff survey for further analysis.
- Links had been established with the People Plan team, and the Workforce Compendium project is being explored with a view to including patient safety specialists.
- It was noted that several national patient safety alerts had now been issued under the new credentialing system - designed to improve quality, consistency and utility of information dispatched centrally to NHS providers. It was discussed that there is more work to do to understand how these alerts are

being acted upon, and how the NHSI/E regional teams have sight across trust compliance with alerts in their patch.

**Action:** Regional and national PS team to continue the discussion on monitoring national patient safety alert compliance in regions.

- The Patient Safety Incident Response Framework (PSIRF) was discussed as significant progress had been made since the last SOC meeting. It was noted that the new Framework marks a departure from the current Serious Incident Framework in a number of respects. The Committee discussed the complexity of implementing a framework that (for example) removes the arbitrary incident investigation deadline of 60 days, while avoiding investigations taking so long that useful learning at the end is unlikely. The challenge is to ensure that all organisations can interpret the framework in the spirit intended, and use the deliberate flexibility it introduces to support the conduct of high quality investigation that leads to sustainable and effective reduction of risk. The early adopter sites are keen to start testing the draft PSIRF and will launch in a staggered fashion from March to May, after completion of a readiness assessment. It was noted that the principles and values that are central to the PSIRF must be reflected and reinforced in the patient safety syllabus. It was noted that it will be important to set clear expectations for all stakeholders (patients/families, the trust, the local system leaders etc) to help create the environment in which PSIRF can succeed.

**Action:** Health Education England (HEE) to have oversight of where PSIRF values can be reinforced in the emerging PS syllabus and training offer that will follow.

A question was raised about the extent to which the patient safety strategy links to the intensive support regime being implemented in the Improvement directorate, for organisations who have been identified as struggling. It was noted that more work is required to identify the potential safety contribution in this.

**Action:** PS team to link with colleagues in the Improvement directorate to explore the potential patient safety support offer for struggling organisations/systems.

## **2) Patient Safety Syllabus**

SOC heard an update on the syllabus development process. The intention remains to finalise the first syllabus by end March 2020, following conclusion of the consultation period at the end of February. It was also noted that there will be an opportunity to adapt the syllabus further later this year. Work has begun to plan development of a draft e-learning module with e-learning for health, which will be the patient safety 'essentials' training applicable to all NHS staff. There remains a question about how this essentials module will be embedded in induction once finalised and what other modes of delivery might be useful in addition to eLearning.

There was a discussion about how training modules (both 'essential' and more specialist modules) will be tested and refined. HEE has received bids from

healthcare teams to test training modules as they are developed. HEE are also exploring some other internal funding sources to support delivery of the syllabus.

It was noted that the Patient Safety Collaboratives (PSCs) would like to explore their role in supporting the development of specialist training, and that patient safety partners should have access to testing the essentials module as one of the intended recipients alongside NHS staff.

**Actions:**

HEE to explore role of PSCs in testing the specialist training modules.

HEE and NHSI/E to explore the opportunity to involve patients in the testing of the essentials module.

**3) Medical Examiners**

Trusts have made significant progress in recent months. Latest intelligence from Regional Medical Examiners suggests more than half those expected to set up an office have appointed medical examiners, with more trusts expected to make progress in coming weeks.

The committee discussed the importance of considering the quality of roll out as well as the numbers. The ultimate aim is for consistency, quality and independence of the Medical Examiner function.

It was reported that two Patient Safety Partners had joined the Medical Examiner implementation group, and that planning is underway to extend Medical Examiners to community care settings.

**4) Risk register and next quarter objectives**

The risk register was reviewed. No further risks were raised at the meeting.

**5) Strategy refresh**

The committee discussed the process and timeline for refreshing the strategy after year one. There was a desire to include more information around the developments that are happening with workforce and the People Plan due for publication in spring. The refresh would also reflect the updates on implementation of the original strategy. The aim is to have the refresh completed in time for Patient Safety Congress 2020. It was agreed that we should plan which strategy elements would be timely to pick out for sessions, and link where possible to the congress sessions of the PSCs.

**Action:**

NHSI/E to continue planning for Patient Safety Congress, and identify links with planned sessions of the PSCs.

**6) AOB**

**Action:** It was agreed that committee terms of reference, membership, and meeting notes would be published from this meeting onwards.

**7) Date of next meeting: 05/05/20 10.30 – 12.00 (half hour extension tbc)**

**Action list:**

- SOC members are invited to send further feedback on terms of reference and membership to the secretariat.
- Regional and national PS team to continue the discussion on monitoring national patient safety alert compliance in regions.
- Health Education England (HEE) to have oversight of where PSIRF values can be reinforced in the emerging PS syllabus and training offer that will follow.
- PS team to link with colleagues in the Improvement directorate to explore the potential patient safety support offer for struggling organisations/systems.
- HEE to explore role of PSCs in testing the specialist training modules.
- HEE and NHSI/E to explore the opportunity to involve patients in the testing of the essentials module.
- NHSI/E to continue planning for Patient Safety Congress, and identify links with planned sessions of the PSCs.