NHS Improvement

Final agreed

Terms of Reference

National Patient Safety Alert Committee (NaPSAC)

Document filename: Terms of reference			
Directorate/ programme	NHS Improvement	**Project**	Creating a credentialing system for Patient Safety Alerts
Lead	Dr Aidan Fowler	**Status**	FINAL
Owner	Dr Frances Healey Dr Matt Fogarty	**Version**	V2.1
Author	Dr Frances Healey Dr Matt Fogarty	**Version issue date**	31/08/2018

Document management

Revision history

Version	Date	Summary of changes
V.1.0	23/03/18	Initial Draft Document for Review (background, proposal and ToR)
V. 2.0	06/08/18	Revised ToR
V. 2.1	31/08/18	Revised ToR after minor comment at 14/08/18 NaPSAC

Reviewers

This document must be reviewed by the following people:

Reviewer name	Title/responsibility	Date	Version
Dr Aidan Fowler	NHS National Director of Patient Safety, NHS Improvement		
Dr Kathy McLean	Executive Medical Director, NHS Improvement		

Approved by

This document must be approved by the following people:

Name	Signature	Title	Date	Version
Mr Aidan Fowler on behalf of all members of NaPSAC		NHS National Director of Patient Safety, NHS Improvement		

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Contents

1 Background

1.1 The core purpose of NaPSAC is to agree, progress and oversee systems which will clearly identify which nationally-issued patient safety advice and guidance is safety-critical.

1.2 This clarity is important for increasing providers' understanding about which safety-critical actions must be implemented by them. It is also an essential precursor to more effective systems through which compliance can be robustly monitored.

1.3 The focus of NaPSAC is on ensuring common standards and thresholds in the processes by which each and every 'authorised' body designates any of their communications as a 'nationally credentialed patient safety alert'. The urgency of many patient safety issues means it would not be realistic for the overarching body to approve the designation of individual Alerts before they are issued.

2 Purpose of NaPSAC

2.1 NaPSAC has been established to design and become the body with responsibility for ensuring the clarity and efficacy of communication that will enable providers to recognise and implement safety-critical actions

2.2 It will operate on a membership and mutual basis to:

2.3 Develop the ways of working by which NaPSAC that 'authorises' National Patient Safety Alert issuing bodies

2.4 Agree and maintain membership of NaPSAC, including membership from all nationally credentialed patient safety alert-issuing bodies, and others as agreed

2.5 Agree its own ways of working

2.6 Agree and maintain the mechanism for designating bodies so they are authorised to issue 'nationally credentialed patient safety alerts' and the associated systems for maintaining and if necessary withdrawing authorisation.

2.7 Agree and maintain the criteria for issuing a 'nationally credentialed patient safety alert' that specifies mandatory safety-critical actions that must be taken by healthcare organisations.

2.8 Agree and maintain the criteria for any sub-types of ‘nationally credentialed patient safety alert’, and ensure these sub-types relate only to logistics of organisational response, rather than suggest ranking of importance (as by definition all are mandatory and safety critical)

2.9 Agree and maintain the title, form and format for ‘nationally credentialed patient safety alerts’

2.10 Agree the route(s) of communication and dissemination of ‘nationally credentialed patient safety alerts’

2.11 Agree the mechanism for self-reporting of compliance with ‘nationally credentialed patient safety alerts’ by organisations

2.12 Agree ‘go live’ date for the ‘nationally credentialed patient safety alert’ system

2.13 Advise on the approach of regulators and other supervisory bodies to regulating compliance with ‘nationally credentialed patient safety alerts’

2.14 Periodically review how these arrangements are operating

3 Scope of NaPSAC

3.1 NaPSAC is focused on communications directed at organisations and requiring specific coordinated organisational action by a specified date to address risks that are life-threatening or involve risk of disability to patients.

3.2 The work of NaPSAC explicitly excludes non-safety critical communications, guidance that does not require action to be completed by a specified date, information directed at individual healthcare staff (i.e. informative ‘safety messages’), or risks to staff or the public.

3.3 NaPSAC would operate in England only, and efforts to align Alerts across the UK would continue to be led by MHRA in the broad sense, and also progressed by specific alert-issuing bodies in England

3.4 NaPSAC will not be responsible for the commissioning or delivery of technical platforms for disseminating ‘nationally credentialed patient safety alerts’ and collecting subsequent responses from providers on action taken, other than as described in 2.10

4 Membership of NaPSAC

4.1 NaPSAC will be chaired by the NHS National Director of Patient Safety (as already decided by Secretary of State).

4.2 The NaPSAC Deputy Chair will be the CQC Chief Inspector of Hospitals (as already decided by Secretary of State).

4.3 NaPSAC membership will include relevant individuals from each of the 'nationally credentialed patient safety alert' issuing bodies. These individuals must be authorised to take decisions on behalf of their body/team in relation to this work. The following bodies/teams are initially represented at NaPSAC on the basis that they either currently directly issue safety messages via CAS or intend to develop the facility to do so:

NHS Improvement's Patient Safety Team
NHS Improvement's Estates and Facilities Team
MHRA Devices
MHRA Drugs
DHSC Supply Disruption
Public Health England
NHS Digital
Office of the Chief Medical Officer
NHS England Primary Care Operations
NHS England Emergency Preparedness & Response

4.4 NaPSAC patient and public representation is initially proposed as two PPV; this would be kept under review

4.5 NaPSAC would also have membership from groups who do not issue Alerts but have a key interest in ensuring the Alerting system is effective. These are currently covered by the membership above, but would be kept under review

4.6 The devolved nations have an interest in the work of NaPSAC in so far as this has implications for the devolved nations. Invitation as observers will be extended to each of the three devolved nations (one observer per nation)

4.7 NaPSAC coordination and secretariat would be provided by the NHS Improvement Patient Safety team (as already decided by the Secretary of State)

5 Accountability

5.1 NaPSAC's route of accountability is to the National Quality Board, subject to confirmation at a future NQB

6 Ways of working

6.1 NaPSAC will determine its own ways of working but these initially include the following:

6.2 To be quorate, NaPSAC must include the Chair or their Deputy and two thirds of members

6.3 NaPSAC will meet quarterly initially, and at intervals it determines appropriate thereafter, with meeting dates agreed at least 2 months in advance

6.4 Papers and items will be circulated 5 working days in advance of meetings. Late papers will not be considered unless otherwise agreed with the Chair.

6.5 Agendas, minutes and papers will be published unless this is not possible without breaching information governance and confidentiality duties.