National Patient Safety Alert Committee (NaPSAC)

11:00 – 12:30 Monday 17th December 2018

DRAFT NOTES UNTIL CONFIRMED AS A CORRECT RECORD BY NaPSAC

Attended	On behalf of (name)	On behalf of (organisation or alert-issuing body/team)
Aidan Fowler	-	Chair/ NHS Improvement
Ted Baker	-	Deputy Chair/CQC
Gina Radford	Dame Sally Davies	Chief Medical Officer*
-	-	DHSC Supply Disruption*
Mick Foy	John Wilkinson	MHRA (Medical Devices) *
-	June Raine	MHRA (Drugs)*
Manpreet Pujara	Martin Severs	NHS Digital*
David Geddes	-	NHS England (Operations)*
-		NHS England (EPRR)
Michael Bellas	Simon Corben	NHS Improvement (Estates and Facilities) *
Frances Healey		NHS Improvement (Patient Safety) *
Meng Khaw	Paul Cosford	Public Health England
* Indicates bodies/teams already issuing their own alerts directly via current CAS process (or set up to do so)		

Observers:

Richard Owen (for link to the National Quality Board)

Jennifer Benjamin (DHSC)

Victoria Chaplin (NHS Digital)

Kate Harley (for Scotland)

Andrew Evans (for Wales)

Ben Scott (for CAS)

Apologies:

Stephen Groves (NHS England EPRR)

David Wathey (DHSC Supply disruption)

1. Welcome and introductions

AF welcomed all parties and emphasised this endeavour is an opportunity to ensure the production and implementation of safety alerts becomes a more powerful and effective mechanism for improving the safety of patients, with leadership, improvement and regulatory attention directed to best effect.

TB gave a brief verbal update on CQC thematic review of Never Events about to be published, covering aspects of most relevance to NaPSAC (see *Opening the Door to Change* published 19 December 2018).

2. Draft notes of 14 August 2018 meeting and outstanding actions

It was confirmed that previous meeting notes had been confirmed as a correct record via email, and the and final version of Terms of Reference discussed had been agreed via email.

AD confirmed devolved nation observer invitations sent 4th September 2018: action complete.

AD noted that NaPSAC agreed as sub-committee of NQB on the 6th December 2018: action complete.

FH gave an update on PPV recruitment; recruitment is underway (update note: recruitment completed).

FH gave an update on National Patient Safety Alert template design workshop held on 18th October 2018 (update note: series of consultation WebEx meetings with NaPSAC members and via email with trust executives, template now at version 3 and going through final design for NaPSAC confirmation).

No actions needed to be carried forward.

3. National Patient Safety Alert criteria

Criteria confirmed as agreed with the following amendments

(Note numbering this section of notes reflects section numbering in the NaPSAC criteria)

2.4 The threshold was agreed at the last NaPSAC. However, following from discussions; a request for neater wording/clarity check to ensure it encompasses healthcare intervention for harm from public health issues and recognises disability/death could be deferred (e.g. Creutzfeld-Jacob exposure could result in death/disability many years later).

Also noted importance of ensuring this threshold information when published is in the context of being genuinely important to ensure the most serious risks get the most urgent attention rather than suggest we are not concerned about other levels of harm.

“Healthcare action could prevent at least one death or disability per year” with footnotes that the one per year is not a definition of immediacy but a definition of frequency (i.e. not so rare that only one will occur every ten years) and ‘could prevent’ is defined as ‘more likely than not’ rather than ‘slight possibility’ (reference PRISM studies).

3.8 Amended wording added ‘for intended issuer’ after ‘clarity’.

ACTION: FH to revise NaPSAC criteria wording accordingly for final conformation by NaPSAC via email.

4. National Patient Safety Alert credentialing process for Nation Patient Safety Alerts

(Note numbering this section of notes reflects section numbering in the NaPSAC credentialing process)

2.1 Preparing for assessment

Period of transition and review to be confirmed at future NaPSAC – current alert issuing bodies continue to issue their existing messages/alerts alongside any bodies that become issuers of National PS Alert for a dual-running period. Length of dual-running difficult to agree until initial alert issuers have worked through the process, but all agreed will need to be an end date at some point, and that it would be undesirable for dual-running to continue for longer than around one year.

2.2 External assessment

All agreed the proposed approach in principle. Request was made for tone to be more of mutual support to raise standards although agreed ultimately the credentialing process must be NaPSAC confirming if an alert issuing body/team has met criteria to become an issuer. Include practical measures to speed process (e.g. invite alert issuer and allow resolution of issues on day of assessment where possible, recommend conditional approval subject to minor additional evidence being provided).

Trio approach to assessment agreed and NaPSAC members asked to think about who they would nominate as assessors to ensure an effective, supportive but not pedantic or bureaucratic approach.

AF noted initially any of the current alert issuers would have to act as assessors but once any credentialed National PS Alert issuers exist they should be the group peer assessors are drawn from.

There were suggestions one alert issuer could demonstrate how to apply, and this initial assessment could act as a model that other alert issuers could learn from. AF offered NHSI PS, FH confirmed willing but suggested we should continue to be mindful we can all learn from each other, rather than solely wait and learn from first full attempt.

AF noted we would also need a process in principle should we choose to not credential a body and where there might be some complaint about that; the paper proposed a process for using NaPSAC as the ultimate arbiter in the unlikely event that an alert issuer disputed the outcome of their assessment, and this approach was agreed.

All agreed there are important issues following initial assessment that will need resolution at a future date (e.g. how many years the credentialled status lasts, how lapses in compliance with agreed standards are managed, and how applications for renewal are managed) but these do not have to be decided at this point.

All agreed there should be iterative feedback and adaptation of the logistics of the assessment process to ensure it is neither onerous nor tokenistic, with each team of applicants and assessors being offered de-briefs to suggest how the process could be improved.

ACTION: FH to revise proposals on assessment process to be confirmed by NaPSAC.
ACTION: NHSI Patient Safety to prepare to be the first applicant for credentialed status.

5. National Patient Safety Alert body/team remit

Discussed and all agreed 'overlaps' could be managed, including through joint-badged alerts and these could in many cases be recorded as 'partnership areas' rather than 'overlap'. However, the partners need a system to agree who will lead the process of alert development for each issue arising in an 'overlap' area.

MK noted that MHRA remit also covers counterfeit medicines and illicit drugs where they work with PHE.

TB noted that ultimately identifying gaps more important than identifying overlap.

ACTION: FH to add need for system in place to agree lead for any 'partnership areas' to NaPSAC criteria

ACTION: All with 'overlaps' to discuss with their counterpart partner before next NaPSAC if they are 'joint badged' areas or simply areas for clarification (i.e. where roles don't actually overlap but current descriptors may make it sound as though they do).

ACTION: FH to make minor amends to MHRA & PHE remit to encompass counterfeit drugs/illicit drugs.

FUTURE AGENDA ITEM: Review revised remit document for next NaPSAC, including discussion of potential gaps where it appears no team/body considers within their remit.

6. The Central Alerting System (CAS)

BS from the MHRA Central Alerting System team presented a CAS presentation.

DG provided an update on the current systems in place for NHS England and the cascading model for alerts to primary care (GP practices, community pharmacies and dental practices) as well as the ongoing work to improve this.

MHRA asked if NaPSAC could confirm that CAS will be the system to issue National PS Alerts alongside other safety communications for organisations and individuals; FH noted this would require more discussion as original NaPSAC proposal document suggested an exclusive channel for National PS Alerts, and the regulatory weight placed by CQC on future National PS Alerts might require more evidence of alert receipt and action declared as taken beyond trust sector. AF proposed a workshop to determine the characteristics needed for a dissemination/acknowledgement/declaration system for National PS Alerts followed by mapping of current and planned capacity of CAS to meet those, and discuss at next NaPSAC.

NaPSAC confirmed it needs to be very engaged in how National PS Alerts will be disseminated (ToR 2.10 *Agree the route(s) of communication and dissemination of 'nationally credentialed patient safety alerts'*) whilst acknowledging CAS is delivered by MHRA (ToR 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*).

ACTION: BS to invite NHS Digital to CAS User Governance Group **ACTION:** FH to arrange workshop on communication and dissemination of future National PS Alerts as proposed by AF
7. AOB and agree any key agenda items for next NaPSAC
Key future agenda items agreed: Review revised remit document for next NaPSAC, including discussion of potential gaps where it appears no team/body considers within their remit. Discuss how NaPSAC will set out expectations for how National PS Alerts should be managed and acted on within providers (whether large or small, whatever sector). Approach to communication and dissemination of future National PS Alerts in light of workshop and CAS mapping against identified needs
DATE OF NEXT NaPSAC Diary invitation to follow

Action Log		
Action	**Who by**	**Completed**
1. To revise NaPSAC criteria wording accordingly for final confirmation by NaPSAC via email	Frances Healey	Yes
2. Revise proposals on assessments process to be confirmed by NaPSAC via email	Frances Healey	Yes
3. NHSI Patient Safety team to prepare to be the first applicant for credentialed status.	NHSI PS team	Preparation advanced
4. Add need for system in place to agree lead for any 'partnership areas' to NaPSAC criteria.	Frances Healey	Yes
5. All with 'overlaps' to discuss with their counterpart partner before next NaPSAC if they are 'joint badged' areas or simply areas for clarification (i.e. where roles don't actually overlap but current descriptors may make is sound as if they do).	All	
6. To make minor amends to MHRA & PHE draft remit to encompass counterfeit drugs/illicit drugs.	Frances Healey	Yes
7. Invite NHS Digital to CAS User Governance Group.	Ben Scott	Yes
8. To arrange workshop on communication and dissemination of future National PS Alerts as proposed by AF	Frances Healey	Workshop held 29 Jan