National Patient Safety Alert Committee (NaPSAC)

23rd July 2019, 2.00pm to 4:30pm

Attended	On behalf of (name)	On behalf of (organisation or alert-issuing body/team)
Aidan Fowler [AF]	-	Chair/ NHS National Director of Patient safety
Ted Baker [TB]	-	Deputy Chair/CQC
Frances Healey [FH]	-	NHS Improvement Patient Safety Alerts *
Niomie Warner [NW]	-	Head of Patient Safety Alert Committee Programme
Cindy Taplin [CT]	-	Patient Safety Alert Credentialing Manager
Bruce Warner [BW]	-	DHSC Supply Disruption (medicines)*
John Wilkinson [JW]	Ian Hudson	MHRA (Medical Devices) *
June Raine [JR]	Ian Hudson	MHRA (Drugs)*
Manpreet Pujara [MP]	Martin Severs	NHS Digital*
David Geddes [DG]	-	NHS England (Operations)*
Michael Bellas [MB]	Simon Corben	NHS Improvement (Estates and Facilities) *
Meng Khaw [MK]	Paul Cosford	Public Health England
Paul Stonebrook [PS]		DHSC
Jono Broad [JB]	-	PPV
Neill Vinter [NV]	-	PPV
* Indicates bodies/teams issuing their own alerts directly via current CAS process (or set up to do so)		

Observers/guests:

Victoria Chaplin [VC] (NHS Digital)

Naomi Gregg [NG](Scotland)

Dr Sara Davies [SD] (Scotland)

Andrew Evans (for Wales)

1. Welcome and introductions

AF - introduced newest members of NaPSAC, Niomie Warner, Cindy Taplin, PPV's Neill Vinter and Jono Broad and new Scottish observer Naomi Gregg and visiting Scottish observer Dr Sara Davies and extended a welcome to all parties in the room and on WebEx.

2. Notes and action log from 17th December 2018 meeting

Previous meeting notes had been confirmed as a correct record via email.

AF confirmed action log was completed except for action 5 (remits) and asked the group if they had had an opportunity to meet or discuss with partners any overlapping remits.

Action: NW to arrange meetings with each originator organisation to discuss remits and any overlapping areas.

3. National Patient Safety Alert credentialed criteria

FH reminded members that although the NaPSAC criteria was confirmed as final that NaPSAC could update and revise when required.

A point of discussion was raised by PPV JB around the best term and reference source to describe disabling/severe and serious harm.

During discussions MP raised a similar concern referring to the QRisk alerts which had potential for death and disability.

AF noted those are good examples for thinking through how this might support better communication in the future. in terms of broad messages on all reporting, including no harm incidents, being vital. In relation to NaPSAC criteria, agreed the term disability and established reference source remained the best approach.

4. NaPSAC Template

FH reminded members that the overall layout of the template had been debated and agreed but we needed a final decision on the logo for the template.

Members were asked for first impressions before moving to a vote. After a brief discussion by a show of hands logo 1A was selected.

TB requested changes to phrasing on CQC role within the template.

Action: TB to advise on the language used in red footer on the template.

Action: NW & CT to finalise NaPSAC template

5. National Patient Safety Alert credentialed status assessment

It was reiterated to the group that the assessment process was confirmed as final but note NaPSAC can update and revise when required. A question was raised around how NaPSAC would deal with emerging concerns that standards were not being maintained and how credentialled bodies would be held to account once they have gone through the process.

JB recommended bodies complete an annual compliance audit on themselves or of others. Members also suggested a peer audit comparable to those used within Royal Colleges. MP asked if there was an expectation that members would be reviewing each alert or each other. It was agreed that whichever route was taken it needed to be a formal approach which included support to help build and improve each other.

Action: NW & CT to explore annual compliance audit options and a process for responding to any specific concerns raised between annual audits.

NW provided an update on the credentialing status for NHS Improvement patient safety. The panel felt that NHS Improvement had provided rigorous and robust evidence and has recommended credentialled status without conditions for 3 years and was looking to the committee to ratify the decision.

The members endorsed the panel's decision and sent their congratulations to Graeme Kirkpatrick and the team.

Action: NW and CT to circulate a brief report detailing the NHS Improvement credentialing assessment as well as lessons learnt which is to be shared with the group via email.

Conversation centred around how well the criteria held up overall but noted that there where sections of the criteria that required some clarification/context.

FH explained to members the section that required clarification was where the criteria states that if there are any circumstances in which the alert originator would not consult with stakeholders and patient public voice representatives. This should only be the case in extraordinary circumstances; however the criteria doesn't dictate the circumstances; the body applying for credentialing must stipulate what they would consider as exceptional circumstances where they would not consult with any stakeholders. If an applying member needs to have exclusions it is important to stipulate these.

SD (Scottish Observer) raised a question regarding the criteria. ToR reference point 3.3 states that NaPSAC would only operate in England but the MHRA is the regulatory body for medicines and medical devices across the UK. When organisations whose remit is not solely England applies for credentialing will there be any questions about the wider UK. For instance, in the criteria point 2.4 it says "NaPSAC agreed the threshold of 'more likely than not one or more potentially avoidable deaths or disability in healthcare in England in a year'.

FH addressed the concerns around wording in the criteria and explained that the yield (more likely than not one or more potentially avoidable death or disability per England) was meant to be frequency as we have access to those statistics; rather than not being mindful of the devolved nations so could be changed to something like 1 death per 50 million. It was also explained that the alert template could be adapted for UK bodies.

Action: NW to invite an observer from the devolved nations to the next credentialing panel that involves a UK wide body.

Action: NW to check any other points where the NaPSAC criteria need a minor change in language to avoid direct reference to England.

AF reminded members that we would like to get all bodies credentialed within a year.

Action: NW to work with members to identify suitable time lines with members to apply for accreditation.

6. The Central Alerting System – workshop conclusions and gap analysis

NaPSAC is responsible for agreeing 'the route(s) of communication and dissemination of 'nationally credentialed patient safety alerts' in it's ToR, but 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 above. The MHRA hosts CAS, having taken the function over from DHSC, partly because at the time the majority of communications issued via CAS were from MHRA.

JR/JW gave a helpful assessment of the gap between the requirements for an effective system to disseminate National Patient Safety Alerts and collect organisational responses. It was agreed that the current CAS system was not fit for purpose and there was a piece of work to be undertaken to see if the CAS platform itself was developable or needed replacement. This would need to involve how, the cost, how it is paid for and who is best placed to develop. It is important to note that this development exercise is not funded. The funding for development/new a system would require a policy view from the Department of Health and Social Care.

Key points from this discussion;

- who leads on developing at the system and what that might look like;
- How National Patient Safety Alerts are issued and where they go;
- How we communicate other non-alerts but important information/communications including information for organisational action but below NaPSAC thresholds;
- Information that is not directed at organisations but is intended for individual healthcare practitioners to read and remember and/or to make changes to their professional practice and how that might be linked to professional organisations

FH noted that NaPSAC purpose was the first bullet, with the wider associated messaging work separated off for delivery by other partners at the point NaPSAC was created.

TB reminded the committee that legal responsibility to action alerts is the registered provider and therefore they must have a channel to receive the information which they are reliably maintaining and that alerts must be aimed at them. Accountability to communicate alerts with front-line staff lies with the legal entity although where possible we should inform people by other routes. Communication must be clear with providers and a new system needs to have capability to use a variety of communication methods. This must incorporate independent health care providers who often provide care to NHS patients. There is an expectation that the Maddison enquiry report (looking at safety and quality in the independent sector) may impact alerting and not to lose sight of the Independent Healthcare Provider Network.

A discussion was held around how we get organisations and professionals to register for these alerts. Some options to consider was reaching out to other regulators including the GMC and NMC and professional developmental bodies and professional organisations; and to consider making receiving this information as part of re-validation and possible revisiting good medical guidelines for doctors. Discussion emphasised that care is needed not to confuse requirements for system action by organisations with personal knowledge and behaviour change by individuals.

A new system would need to have two processes with a common database of connectivity and to allow registered users/organisations to manage their own subscriptions directly. Possibly considering a mass general application. A new system must be fit for purpose for all users and far reaching (e.g. locums).

There was an in-depth discussion around alerts and non-alerts (not meeting the NaPSAC threshold) and how best to get this information out. Bulletins could be a useful route for reducing communication burden (multiple issues in a monthly communication) but noted some the non-alerts did not fit into a bulletin format and they should change clinical practice and for the sake of patients they should be actioned. We would not want an unintended consequence that by focusing only on NaPSAC alerts that we may draw attention away from other important communications which still have accountability. We must consider the language used when describing NaPSAC alerts and non-alerts, we must be cautious when using a very simplistic definition of alert versus non-alert, whilst recognising the intent of NaPSAC and its work to date is aimed at creating a clear distinction. We should consider working up an options/appraisal/taxonomy. It was agreed that it is crucial to have a communication plan around the branding of alerts vs other safety communications.

FH noted that NaPSAC and the very small team dedicated to supporting was not designed to resolve the entirety of safety communications, but it should be possible to support initial discussions on what needed to be done and how that could be taken forward.

Action: Arrange a workshop to discuss non-alert communications and next steps. Invite a representative from NICE.

7. Communication Plan

NW discussed with members our communication plan for publicising NaPSAC and the move to NatPSAs – publicising the start of the credentialing process with our first originator having successfully been accredited. A plan in being pulled together to identify the mechanisms we should be using to get our message out and to get the contact details for comms teams from each of our members so we can work with them to get the message out.

It was agreed that we would need to identify who we are communicating this information to. We should consider reaching out to the Royal Colleges and major stakeholders.

It was acknowledged that there would be a risk if we started to issue NaPSAC alerts from credentialed bodies without a communication plan. The committee agreed that a phased approach was appropriate, and organisations would need to understand that there would be a transition period in which NaPSAC credentialled alerts appear alongside existing alerts, and we needed to ensure we communicated this approach across to the healthcare system, but it was important to maintain momentum and publicise NaPSAC's work as soon as the plan was in place.

Action: All NaPSAC members to provide contact details for their comms team

Action: NW & CT to put together communications plan and share with NaPSAC members

8. AOB

Discussion centred around the next piece of work that would need to be picked up – the evolution of the committee beyond its current purpose to a wider cross-ALB safety committee. Some of the key points which were discussed were that in relation to HSIB recommendations and other similar national safety work, this committee could mirror the concept of the Transport Safety Committee.

It was suggested that the different ALBs got together on a regular basis to discuss safety issues. How that looked and worked could take a number of forms; it could be very strategic - or it could be a combination of strategic and operational discussions about what we need to know, who needs to be involved, each ALB's contribution, and then progress to the next safety issue.

JW highlighted the learning MHRA had taken away from the Baroness Cumberlege Review; is the question of who is in charge when things go wrong. The review is likely to recommend something which allows a coordinated response.

The committee agreed that there would be value in this concept. The members said they would need to look at the governance, ToR, membership and consideration would need to be given to who the new group would report to. The group also suggested looking internationally to see if there are any comparative committees.

The committee agreed on the importance of the new group being empowered to act and propel action.

Action: AF/NW to draft ToR for NaPSAC 2.0 and gain some insight into what this group might look like.

Chair: thanked all members for attending and for their contributions to the discussions and closed the meeting.

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	Yes
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	Yes
9. Action: NW to arrange meetings with each originator organisation to discuss remits and any overlapping areas.	Niomie Warner	Yes
10. To advise on the language used in red footer on the template.	Ted Baker	Yes
11. To finalise NaPSAC template	Niomie Warner & Cindy Taplin	Yes
12. To explore annual compliance audit options and a process for responding to any specific concerns raised between annual audits.	Niomie Warner & Cindy Taplin	In progress
13. To write up a report detailing the NHS Improvement credentialing assessment as well as lessons learnt which is to be shared with the group via email.	Niomie Warner & Cindy Taplin	Yes
14. To invite an observer from the devolved nations to the next credentialing panel that involves a UK wide body.	Niomie Warner	In progress
15. To check any other points where the NaPSAC criteria need a minor change in language to avoid direct reference to England.	Niomie Warner	Yes
16. To work with members to identify suitable time lines with members to apply for accreditation.	Niomie Warner	Ongoing
17. Arrange a workshop to discuss non-alert communications and next steps. Invite a representative from NICE.	Niomie Warner	Yes
18. NaPSAC members to provide contact details for their comms team	All	
19. Put together communications plan and share with NaPSAC members	Niomie Warner & Cindy Taplin	Yes
20. To draft ToR for NaPSAC 2.0 and gain some insight into what this group might look like.	Aiden Fowler/Niomie Warner?	Ongoing