National Patient Safety Alerting Committee

Thursday 26th November 2020, 15:30 to 17:00

Attending	On behalf of (name)	On behalf of (organisation or alert-issuing body/team)
Aidan Fowler	-	Chair/NHS National Director of Patient Safety
Ted Baker	-	Deputy Chair/CQC
Jono Broad	-	PPV
Neill Vinter	-	PPV
Ethel Oldfield	-	Head of Patient Safety Oversight and Alerts/logistical support to Committee
Cindy Taplin	-	Credentialing Manager/logistical support to Committee
Rebecca Chaloner		Department of Health and Social Care (PS portfolio)
Sumaia Mashal	-	DHSC – Medicine Supply Disruption*
David Wathey		DHSC – Medical Device Supply Disruption*
Bruce Warner	-	NHSE/I clinical advice for Supply Disruption
Michael Bellas	Simon Corban	NHS England & Improvement (Estates and Facilities) *
Frances Healey	-	NHS England & Improvement Patient Safety Alerts* /leading team providing logistical support to Committee
Graeme Tunbridge	June Raine	MHRA (Medical Devices) *
Sarah Branch	June Raine	MHRA (Medication) *
Manpreet Pujara	Martin Severs	NHS Digital*
Jackie Lamberty	Amal Rushdy/Paul Cosford	Public Health England*
Kevin Harris	-	NICE
Alastair Henderson	-	Academy of Medical Royal Colleges
Keith Conradi	-	HSIB
Natasha Phillips	-	NHSX
Sue Tranka		NHS England & Improvement (CNO & HCAI)
* *Indicates bodies/teams issuing their own alerts directly via current CAS process (or set up to do so)*		
Observers		
Meera Sookee (for link to the National Quality Board) Naomi Gregg (Scotland) Sara Davies (Scotland)		
Apologies		
Amal Rushdy – Public Health England Cathy Harrison (Northern Ireland) Andrew Evans (for Wales) Helen Causley – DHSC (may join for HSIB section) Stephen Groves – EPRR Jenny Harries - CMO		

15:30	1. Welcome and introductions

AF – Welcomed all parties to the MS teams meeting and extended a welcomed to Ethel Oldfield who is the new Head of Patient Safety Oversight & Alerts.

AF - Gave a brief overview on how the meeting would progress with the use of PowerPoint slides but asked attendees to introduce themselves when speaking.

Importantly, it was noted that for this group to be as practical and functional as possible, that the membership would be restricted to decision makers. The intention is that decision makers from organisations will attend, robust discussions will be had around issues where we have shared responsibility, and people will agree to their part. If you are unable to attend, you must send a deputy who has delegated authority.

The committee accepted that the notes and action logs from 20th January 2020, 9th July 2020, and 1st September 2020 were accurate.

2. NATIONAL PATIENT SAFETY ALERTS (NaPSAC) section of meeting	
15:35 – 15:45	2a. Accreditation process to date

CT – Gave an overview of the accreditation process to date. The patient safety team within NHSE/I have to date issued 9 National Patient Safety Alerts and AF congratulated the MHRA, who have now published their first National Patient Safety Alerts. It was also noted that other alert issuing bodies were all working towards their goal of accreditation in 2021. It was noted that we still need to confirm leads for EPRR and the CMO's office.

CT – Shared a quick overview of the number of alerts which have been issued from April to September 2018 compared to the same period for 2020, and noted that there had been a dramatic drop in non-critical alerts being issued, and that showed that the credentialling process was having a positive impact even in teams/bodies still working towards formal accreditation.

2a Accreditation Process to date.pdf

AF – Emphasized the importance of alerts; noting that we have never seen alerts as being more important than during the pandemic where it was essential to disseminate requirements for action at speed, noting that the new National Patient Safety Alerts format have much clearer actions. We have also been reminded how some historical alerts were confusing and could potentially lead to ongoing issues.

15:45 – 16:00	2b. Central Alerting System replacement and cross-ALB Safety Messaging/Safety Bulletins

Update on the Central Alerting System replacement

GT –Shared that the MHRA's bid to the Treasury Departments Spending Review (SR) included a specific bid for funding to replace CAS, roughly £4,5 million to cover the IT development and staffing costs involved, forecast into 2021 to 2022. Noting that the MHRA is yet to discover how the settlement the Department of Health receives will flow through the department and onto the ALB's, and if the department would look favourably upon this aspect of the bid or not. The MHRA expect to hear the outcome in early 2021. If the bid is successful then it would take some time to do the work required, so noted that we would still be working with CAS as is, for the foreseeable future, or at least the next year or so. It could go beyond that if the department did not fund the redevelopment. Without funding from the SR, it is unlikely that the MHRA will be able to fund it by themselves.

AF – asked Rebecca Chaloner (from DHSC) if we had an idea if this bid would be supported? RC noted that it would be too early to say, the SR bid only landed on 25th November 2020, but shared that there are processes within DHSC to look at where funding will be spent. Aidan requested that this issue be brought back to the

next meeting noting that it was critical, and that current circumstances had highlighted our concerns regarding the current CAS system.

Action: GT to provide an update following the SR and CAS redevelopment as an agenda item for the next meeting.

Proposed terminology changes to declaration of compliance on CAS

GT – Spoke to the slides (please see slides for in-depth detail).

2b Focusing CAS on safety-crital communi

Group discussion

There was discussion that consideration should be given to rephrasing option 3, to be clear that an alert is relevant for the organisation that one or more actions apply, and similarly to option 4 that none of the actions are relevant, to make it abundantly clear, but there were also views that the alert topic rather than individual actions were the right focus for 'relevance' and the National Patient Safety Alerts routinely specified the types of provider each alert was relevant to. A concern was raised by BW regarding the amount of time an organisation could spend without progress in the period after acknowledgement and thought that interim stages could be considered in the redevelopment of CAS.

After the group discussion it was agreed that the committee was happy with the proposed changes to the alert responses laid out in the slides. It was requested that the CAS team consider publishing the declared compliance data in red/amber/green status report, using colour as an indicator of how long past deadline a National Patient Safety Alerts remained incomplete rather than how many National Patient Safety Alerts per organisation remained incomplete, as any one was a concern.

Update on cross-ALB Safety Messaging/cross ALB Safety Bulletins

GT – Reminded the committee that this was in relation to the action that the MHRA took away previously, around coordinating cross ALB safety messaging outside of National Patient Safety Alerts. Due to the pandemic and Brexit we have not been able to make this a priority. However, it is still an action we are carrying forward.

GT – Shared how the pilot medical devices bulletin is being developed within MHRA and wanted to discuss how this could be broaden out to include other ALBs. Explained that the Devices team decided to introduce a fortnight medical devices safety bulletin, a crisp 2 pager, a roundup of key issues and occasional spotlight on issues, this has replaced some of the other communications we had. This is currently distributed through CAS, as we have no other means available at this stage. But shared that there are plans to redevelop our gov.uk webpages and develop some safety landing pages to enable us to stop pushing the information through CAS. Initially that page will be focused on medical devices and then we will incorporate other safety messaging work within the agency so we can produce a one stop shop and move progressively away from CAS once we are confident that we have an alternate route and that we understand the impact of doing that. Once the MHRA have their own house in order over the next few months then they will be able to pick up the action of starting conversations across ALBs.

Group discussion followed and summarised by AF - we must seek to reserve CAS for the active push out of requirements to take action on safety critical issues, and to resist the temptation to cascade information on problems which have no clear solution or are not safety critical; this may makes us feel better but is shifting the problem rather than helping the service to improve. We should be saying how can the MHRA safety information on medical devices be a resource that people find useful, timely, relevant and easy to digest, where people see it as an authoritative place to go for information, rather than the notion of a safety blanket where we push out all safety messages and then step back and say disaster averted. Where moving from a push system to a pull system we would need to be assured that the people were looking at the information e.g. via log in to gain access so meta data is available as monitoring tool.

16:00 – 16:05	2c. CQC's role in relation to National Patient Safety Alerts

TB – Provided a brief update and highlighted the following:

- CQC have issued new guidance to staff, so they are aware of the new published alerts, closing dates and guidance on how the implementation of alerts should be assessed throughout the regulatory process.
- CQC's insight product assesses and identifies risks using metrics. These metrics have been developed jointly with NHSE&I to ensure that the metrics identify risks in a system when alerts have not been implemented or where there are other risk factors. This has already identified some trusts which have a significant backlog of incomplete alerts.
- CQC are developing a monitoring system to try and reduce the need for onsite inspections, this is a transitional approach and is still developing. Built into that, we have questions where we are asking trusts about their implementation of National Patient Safety Alerts. These questions are designed to identify what assurances trusts have around the implementation of National Patient Safety Alerts. This will be central going forward. If we do undertake risk-based inspections these will be driven by something we have identified from our risk assessment or from other information we receive from other bodies about risks within systems.
- A risk-based inspection is focused on safety as a central theme under the current circumstances. There is some work going on in our mental health inspections teams around issues with anti-ligature guidance which we are working in partnership with the patient safety team to make sure we are implementing that in a consistent way.
- CQC's strategy for the next 5 years will be going out for consultation in the new year, a central theme is around safety. We are looking at culture and safety expertise and the approach that organisations must implement National Patient Safety Alerts consistently. We will be assertively looking at National Patient Safety Alerts to move from a culture where people feel that alerts are one more thing to do, to one where they are central to driving safety forward.

16:05-16:10	2d. Process between re-accreditations

<u>Self-assessment between formal re-accreditation cycles</u>

FH – Spoke to the slides (please see slides for in-depth detail)

2d NaPSAC Process between re-accreditat

<u>Group Discussion</u>

A request was made by JB to amend to point 3, suggesting that it should read, 'that we suggest that it have fresh eyes by involving a patient & public voice AND a senior colleague' rather than 'OR'. All agreed to the amendment. BW also asked if there would be guidance and common audit standards to do their audit against, to ensure consistency in the self-audit process. FH noted that it is a reassessment against the standards you are accredited on, so effectively they are already laid out and agreed by the committee.

FH – Noted if the committee was broadly in agreement with the suggestions then a more detailed protocol would be written up and shared with the committee via email for agreement.

The committee confirmed it agreed with the proposed process.

<u>Concerns raised between re-accreditation</u>

FH spoke to the slides (please see slide pack)

2d NaPSAC Process between re-accreditat

Group Discussion

It was agreed that CQC should be informed of any substantiated concerns raised, because they may not want to pursue enforcement on National Patient Safety Alerts where the content was not in line with agreed criteria. All agreed this should be included into the stages.

JB asked whether the committee should suspend the accreditation of an alert issuer who had committed a third offense until evidence had been submitted to the committee that the issuer had taken all corrective action needed to conform to the standards. In discussion it was felt that the committee should adopt a principle of keeping an organisation functioning until we had the appropriate evidence. But that should National Patient Safety Alert issuer reach stage 3, instead of waiting for the next scheduled committee meeting, that a special short meeting would be called.

Action: EO to revise stages to reflect comments

17:00	**Close & thanks**

AF –Asked the committee to give some thought to the TOR and to consider the membership for the National Patient Safety Committee, reiterating that the committee needs to be tight, not to be exclusive but it is important to have decision making people, this committee needs to be decisive.

Chair: Thanked all members for attending the meeting and wished all a good Christmas.