National Patient Safety Alert Committee

9th July, 10:30am to 11:30am

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 *
Cindy Taplin [CT]	-	Patient Safety Alert Credentialing Manager
David Wathey [DW]		DHSC Supply Resilience (MDCC)*
Sumaia Mashal [SM]	Sarah McAleer	DHSC – Medicine Supply Disruption*
Bruce Warner [BW]		DHSC Supply Disruption (medicines)*
Graeme Tunbridge [GT]	June Raine	MHRA (Medical Devices) *
Manpreet Pujara [MP]	Martin Severs	NHS Digital*
Mona Johnson [MJ]		NHS Digital*
Natasha Phillips [NP]		NHS X
Jackie Lamberty [JL]	Amal Rushdy	Public Health England
Michael Bellas [MB]	Simon Corben	NHS Improvement (Estates and Facilities) *
Jennie Hall [JH]	Sue Tranka	NHS England & NHS Improvement (Nursing)
Cathy Hassell [CH]		NHS England & NHS Improvement
Stephen Drage [SD]		Healthcare Safety Investigation Branch (HSIB)
Keith Conradi [KC]		Healthcare Safety Investigation Branch (HSIB)
Alastair Henderson [AH]		Academy of Medical Royal Colleges (AOMRC)
Kevin Harris [KH]		NICE
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:

Dr Sara Davies (Scotland)

Naomie Gregg (Scotland)

Helen Causley (DHSC)

Apologies

Jenny Harris (CMO)

Sarah Branch (MHRA)

Amal Rushdy (PHE)

Paul Stonebrook (DHSC)

Sue Tranka (NHS England & NHS Improvement – Nursing)

Cathy Harrison (Northern Ireland)

Andrew Evans (Wales)

1. Welcome and introductions

AF - welcomed all parties to the MS teams meeting.

Notes of meetings held on 20th January 2020 previously agreed as correct via email in lieu of cancelled April 2020 meetings. Actions in action logs all complete, on hold, or on agenda for this or next meeting, so not reviewing today. Any additional corrections or updates please email cindy.taplin@nhs.net .

2. National Patient Safety Alert credentialed team update

CT - gave an overview of the number of alerts issued via the Central Alerting System for the same period (March to July) for 2019 and 2020; as expected there had been a dramatic increase in the number of alerts issued – it was noted that the increase in CMO alerts had been attributed to other organisation PHE, EPRR, NHSE&I issuing alerts through the CMO route (as emergency alerts).

CT - shared with the committee that NHS Improvement Patient Safety Team had issued 6 National Patient Safety Alerts to date with 3 issued during Covid-19 pandemic. And reminded the committee that though MHRA had been accredited that they had requested postponing issuing alerts under the new template until September.

AF - asked MHRA for feedback on when they thought they would move to the accredited process and issue in the new National Patient Safety Alert template?

GT - noted that the MHRA are committed to issuing the new style National Patient Safety Alert template in early to mid-September 2020, but that he would look to reinvigorate the process, he commented that they had done a reasonable job in keeping the non-critical alerts to a minimum in times of Covid.

CT - gave an overview of the current status of alert originators credentials status and asked for a revised accreditation date. AF - asked each group to provide a brief update on their progress.

Estates and Facilities – MB

Pre Covid, we undertook a mapping exercise against the criteria and have developed a draft document. Next steps: internal engagement with senior colleagues. The main issue to flag, which is a potential blocker, is internal resources and Covid pressures. Working towards an October 2020 accreditation date.

NHS Digital – MP

Introduced Dr Mona Johnson – senior clinical lead who would be leading on credentialing. The main issue to flag which is a potential blocker is internal resources and Covid pressures. Working towards a November 2020 accreditation date.

DHSC Supply Disruption – supply resilience for medical devices and clinical consumables - DW

Pre Covid, we undertook a review of policies against the criteria to identify any gaps and where additional processes may be needed. The main issue to flag which is a blocker is internal resources; we are still heavily involved in Covid related activities, preparation for a potential second wave, winter pressures as well as work in relation to the end of the transition period (EU). Working towards an April 2021 accreditation date.

DHSC Supply Disruption Medicines – KM

Pre Covid, we mapped current processes to criteria and identified gaps – needed to formalise approach. Identified overlap with PHE with regards to vaccine supply issues which needs further discussions. Further discussions with MSRG also needed to determine how to deal with messages that do not meet the new threshold. The main issue to flag which is a blocker is internal resources we have two experienced members of staff on maternity leave; we are still heavily involved in Covid related activities, preparation for a potential second wave, winter pressures, as well as work in relation to the end of the transition period (EU). Working towards a May 2021 accreditation date.

AF – noted that we will be looking at next steps for EPRR/CMO/PHE; we need to seek clarity around their alerts.

Action: Identify leads to take forward accreditation within the CMO's office and EPRR

Public Health England - JL

JL – updated the group that the accreditation process had been allocated to Amal Rusty, Deputy Director for Excellence and Quality. We have undertaken a mapping exercise against the criteria and identified any gaps. We have developed a draft policy which will require a wider communication exercise within our organisation to drill down the processes. Working towards a January 2021 accreditation date.

3. Provider response to National Patient Safety Alerts

FH - gave a brief overview of 5 of the 6 National Patient Safety Alerts which are now past deadline. It was highlighted that there were several trusts which have alerts open weeks after deadline date.

There was a concern raised around the culture of a tokenistic acknowledgment of an alert as complete before completing the actions. This trend could be seen in the National Patient Safety Alert – Ligature and ligature point risk assessment tools and policies; there were 2 Mental Health trusts whose status was 'action complete' within 3 hours; and a further 2 Mental Health trusts who recorded 'action complete' within 2 days of the alert being issued, despite required actions which would not have been feasible in those timescales.

AF - There are positives; we're issuing the new style alerts and we issued 3 adjusted alerts for Covid in reasonably short order. We issued an Estates and Facilities alert – the oxygen container recognising an immediate concern, which was issued in record time. My concern is we have issued these alerts in order for it to be easier for organisations to comply with them and we are seeing that some just aren't completing the actions and what is really worrying is if organisations are actively telling us they have completed alerts when that is not the case.

4. CQC regulation and inspection of Alert compliance

TB – Responded to AF concerns; those are just the kind of problems we want to address with this work. CQC's work has been disrupted by Covid however they are committed to building National Patient Safety Alerts into the inspection methodology going forward.

TB - Currently CQC are only inspecting for specific risks which have been brought to their attention. There are no routine inspections during the pandemic. The focus has been on building stronger relationship management with all the providers and NHS trusts; building into that relationship management framework there are questions around NatPSA. Holding Trusts to account for their actions should challenge organisations to do well. However, if there is intelligence/evidence where trusts are being misleading, that might trigger a risk-based inspection. Soft intelligence is very important, we need to know where to target our regulatory work. We need to work together on sharing that soft intelligence then we can follow up. FH in subsequent discussion clarified that the information on the early closure or late completion of Alerts is from the CAS data that CQC access, rather than soft intelligence, and work with CQC analytical colleagues to help them make the significance of this more obvious to relationship managers is ongoing.

The CQC are planning to return to a regular programme of inspection through a virtual environment. It is hoped the routine inspection programme will restart in September (pandemic depending). The CQC are strongly committed to building National Patient Safety Alerts into this programme of work.

5. The Central Alerting System Update

AF – reminded the group that alerts go out via the Central Alerting System (CAS) and as previously discussed, it is an old system, we have discussed the sensible way forward is for the system to be replaced. We need a system where we can highlight the NatPSA alerts and maintain a system where people can communicate 'other messages' through another route. We have started discussion with DHSC about how this would be funded; there was always an agreement that this would be a shared funding model, but the alternative is a central funded by DHSC. AF invited Graeme Tunbridge to provide a CAS update.

GT – updated the group. The MHRA obtained CAS in 2012 with old technology that was no longer being supported. The MHRA have propped it up, maintained it and made some improvements and not least tried to make NatPSA alerts stand out; whilst acknowledging that it is a minimal viable product. The MHRA are keen to see it developed. However, funding is currently a blocker. The MHRA are happy to do the discovery work needed to go forward but until there is a clear funding source, they are reluctant to sink time, effort, and money into the discovery phase whilst the funding question remains unresolved. AF - we will continue those discussion with DHSC - it would be helpful to have GT involved with this.

6. AOB

AF - The group agreed for a date in early September 2020.

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

Action log: note past action logs will be combined with actions from this meeting at the next regular scheduled NaPSAC meeting in November 2020