National Patient Safety Alert Committee (NaPSAC)

20th January 2020, 13:30pm to 15:30pm

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 England & Improvement Patient Safety Alerts *
Niomie Warner [NW]	-	Head of Patient Safety Alert Committee Programme
Cindy Taplin [CT]	-	Patient Safety Alert Credentialing Manager
David Wathey [DW]		DHSC Supply Resilience (MDCC)*
Graeme Tunbridge [GT]	June Raine	MHRA (Medical Devices) *
Sarah Branch [SB]	June Raine	MHRA (Drugs)*
Kate Mitchell [KM]	Sarah McAleer	DHSC Supply Disruption (medicines)*
Bruce Warner [BW]	-	DHSC Supply Disruption (medicines)*
Manpreet Pujara [MP]	Martin Severs	NHS Digital*
Andy Carr [AC]	Martin Severs	NHS Digital*
Jennifer Smith [JS]	Paul Cosford	Public Health England
Michael Bellas [MB]	Simon Corben	NHS England & Improvement (Estates and Facilities) *
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:

Dr Sara Davies [SD] (Scotland)

Naomi Gregg [NG] (Scotland)

Cathy Harrison [CH] (Northern Ireland)

Andrew Evans [AE] (Wales)

Apologies

Meng Khaw (Public Health England)

Sebastian Alexander (NHS Digital)

Sarah McAleer (DHSC Supply Disruption (medicines)

1. Welcome and introductions

AF welcomed all parties in the room and on Skype.

2. Notes and action log from 23rd July 2019 meeting

Previous meeting notes had been confirmed as a correct record via email. Actions confirmed as closed, in progress or on agenda to discuss.

3. National Patient Safety Alert credentialed team update

NW updated the committee on the work that has been carried out since the last NaPSAC meeting.

Communication

The NaPSAC website is in the process of being updated to give clearer information to providers and to link to the 3 National Patient Safety Alerts (NatPSA) issued by NHS Improvement. A CAS alert was issued in September to hilight the changes to providers and messages went out via provider bulletins and on social media. There was also an article in the HSJ.

A frequently asked questions is being developed which is being targeted at questions which may arise from executive level staff within providers. We are also working with stakeholders on a communication strategy to target communication at senior level executives within providers This will involve proactively engaging with this group so that they understand what is expected of them. We are linking in with colleagues at CQC, regional teams, NHSE&I nursing directorate and across the bodies going through accreditation, looking for forums to do this.

Alerts issued

3 NatPSAs have been issued since the last meeting. These are:

- Depleted batteries in intraosseous injectors.
- Risk of death and severe harm from ingesting superabsorbent polymer gel granules.
- Risk of harm to babies and children from coin/button batteries in hearing aids and other hearing devices.

AF asked the committee for any initial thoughts, comments and feedback.

TB thought they were clearer, but that it is important to get feedback from the recipients.

JS raised a question regarding 'action at a senior executive level' partly because PHE issue a number of briefings which require action from infectious disease consultants or perhaps A&E; but huge sections of the organisation would not need to be made aware of the briefing; and thought that this would be the same for the alert 'Risk of harm to babies and children from coin/button batteries in hearing aid and other hearing devices'.

FH suggested that this pertains to the differences between 'critical and complex' vs 'critical and straightforward'. Noting that the executive level oversight will always be in place; the hearing aid alert was designated as 'straightforward' as it could be managed within a single department. The other 2 alerts were designated as 'complex' as they required multiple directorates and multiple professional groups, so needed coordination at an organisational level; this could only be done at an executive level.

TB noted that the providers are legally accountable to ensure that these alerts are enacted. So senior executive levels must be aware of the alerts and they must have a system in place to assure themselves that actions have been taken. JB shared insight into the discussions which took place within the PPV group that sat on the panel that looked at these alerts. A discussion arose around the language that was used, especially for the alert, "risk of death and severe harm from ingesting superabsorbent polymer gel granules". JB suggested that 'severe harm' be removed and replaced with disability and suggested that language needed to reflect that set out in the criteria.

FH commented that this is the difference between threshold, where we all need to have a common definition, and what people read in an alert. The shared definition for the threshold is "disability" however as the alert is describing what is being reported into the NRLS we may still use the severe harm terminology within the text of the alert itself. It is however still subject to the same thresholds agreed as part of the criteria.

NW shared feedback she had received from some providers, that overall the alerts are easier to read, and, for them they had a clearer sense of what they needed to do. We will continue to work with providers to get their feedback.

Support for accreditation

6-weekly calls are taking place for all ALBs going through the accreditation process; this allows originators to share knowledge and best practice ideas. Several 1 to 1 meetings have taken place with most alert originators represented on the committee. A shared platform is currently being developed, this will allow alert originators to share their ideas and work together. This platform should be available in the coming weeks.

We held the 'other communication workshop' in November which was well attended.

"Train the trainer" sessions are currently being designed. Working with alert originators to identify useful themes to add to the sessions. Currently will be looking to provide training on what a good alert looks like and how to write SMART actions. Sessions will take place in Feb/Mar.

4. Alert Originators credentialing status update

AF asked each group to provide a brief update on their progress.

DHSC Supply Disruption Medicines – KM

Early stages of process. Useful workshop with NW and CT and colleagues in medical device supply. DHSC medicine supply will be accredited separately from devices due to having very distinct processes. Aim to do this at the same pace as the devices supply team. Have mapped current processes to criteria and identified gaps – need to formalise approach. Have 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. Anticipate accreditation panel in June 2020

BW raised his concerns about what do we do with messages that do not meet the new threshold for alerts.

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

Working together with the medicine supply teams to be as joined up as possible. Currently undertaking a review of policies against the criteria to identify any gaps and where additional processes may be needed. Anticipate accreditation panel by end June 2020.

MHRA – GT

Due to be credentialled February 2020. Undertaking an extensive training programme. The main issues to flag which are potential blockers: the definition around disability; it is defined in legislation in some cases but can also differ across the board; clarity around the 'other communications' and how to process messages that do not meet the new threshold.

NHS Digital – AC

Undertaken a mapping review to identify existing processes and map these against the criteria. Useful meeting with colleagues in Estates and Facilities to share work. The main issue to flag which is a potential blocker is internal resources. Next steps are internal engagement with senior NHS Digital stakeholders to make sure they have the right people to get the internal document approved and to agree a formal date for completion. Working towards a March accreditation date.

Action: CT to arrange a meeting with NHS Digital

Public Health England - JS

PHE have a resource issue but have a new medical director and deputy in place. Several discussions have taken place and blockers identified. Firstly, identifying the threshold; could potentially issue many alerts across a variety of issues, but infectious disease and vaccines are the most common. Need to look at how PHE use the threshold definition; could potentially put all our alerts out but have agreed that internal conversations are needed to identify how to apply the definition and how to deal with those that no longer meet this. Example of complexity: PHE and the police are frequently the only agencies aware of issues around illicit drugs; however, does PHE take that responsibility just because we have the strongest link into the NHS but almost certainly not having people on the ground. These are not all currently issued via CAS but if threshold applied to these would likely increase the number.

FH commented these will either fall into alerts which have systematic organisational actions by a set date or getting information to professionals to ensure they recognise how new abuse of any given drug presents, which, whilst equally important is different to an alert and which will fall into other types of communication.

Action: CT to arrange a meeting with Public Health England

Estates and Facilities – MB

Have undertaken a mapping exercise against the criteria and have developed a draft document. Next steps: internal engagement with senior colleagues – NW has meeting planned with SB and MB in coming weeks. The main issue to flag which is a potential blocker is internal resources. Working towards an April 2020 date for accreditation.

Devolved administrations - AE (Wales) in relation to the devolved administrations; most will take what is issued via CAS and will issue a similar alert with subtle differences. Would there be benefit from having a light process that the devolved administrations can go through afterwards to make sure their alerts don't appear to be less important. Keen to bring devolved administrations in line with alerts coming out via CAS to ensure consistency.

FH highlighted that devolved administrations attend NaPSAC to share those same standards but need to be mindful of the fact that what works for each administration may differ and that they rightly maintain control over whether to adopt e.g. currently the three devolved nations are involved in the development of an NHSI/E Patient Safety Alert but all have different processes for agreeing whether an Alert will be applied for action in their nation, and this varies between using the original NatPSA with a cover sheet and providing an adapted version specific to their nation., whereas for Estates & Facilities Alerts they tend to co-badge. Therefore, different solutions may be needed for the different types of alerts.

AF agreed this was a sensible approach and NaPSAC is happy to support the devolved administrations to develop this.

SD from Scotland agreed that for DHSC medication supply disruption and DHSC medical device supply disruption alerts especially with regards to EU exit that they would want as much similarity as possible.

CH (Northern Ireland) thought that early sight of an alert as well as the ability to influence the content could be useful.

Action: AE/NW to explore a process for what a light touch accreditation may look like for the devolved nations where a NaPSAC accredited Alert has had minor amends and reissue

5. Update from Communications Workshop

The workshop in November 2019 was well attended by all ALBs around the table. Conversation centred around what to do with communication currently being issued via CAS that did not meet the threshold of an alert moving forward.

There was support/consensus amongst the attendees for a patient safety bulletin. This would need to be issued centrally, but which all the alert originators could contribute towards. A system or the correct mechanism would be needed to inform the providers of the 'other communications' that no longer met the alert criteria.
AF shared how HSE have safety alerts and safety notices and noted that aspects of that approach which parallels what we are suggesting.

The group identified that there would need to be cross agency working in order to make this work. It would also need to be managed centrally rather than alert originators working/issuing in isolation.

NaPSAC members are asked to repeat their earlier assessment of current CAS communications to identify of there are alternative routes for those which will not meet NatPSA threshold moving forward. NaPSAC also asked to agree to a working group being set up to take this forward and to identify an ALB to lead.

FH -reiterated the original drive for NaPSAC and the subsequent work undertaken to replace the current system of alerts, notices, messages, letters etc. had been mindful it is important to avoid having two tiers of safety communications that require organisations to take action, as past systems that asked organisations to act urgently on alerts and less urgently on notices, or that had directive alerts, and non-directive alerts had created confusion. There were genuine needs for other types of communications, as set out in the communication workshop paper; but that is distinct from something that is like an alert in terms of requiring action at organisational level but has a different name or status.

BW - agreed that bundled communication would work for some things but equally how it would not work for many other things. Thinking about the work on supply disruption, putting that information into a monthly bulletin will not work. Two issues to consider – the product itself and the dissemination route and both must be thought through.

AF - highlighted the risk of putting everything into a bulletin and it not receiving the necessary traction.

JB commented on the need to consider how the public might view a two-level alerting system. When you consider that individuals may find more relevant issues for them personally in the second level of alerts and may question why the information was not classed as a first-tier alert?

TB commented that it is essential there are not two levels of alerts. It must be clear that an alert is an alert. We must develop ways to communicate with providers in a way that gives very clear safety alerts, but other safety information isn't classified as a safety alert.

GT - highlighted this is a particular issue for MHRA as there are communications which will not meet the threshold of a NatPSA. MHRA is happy to take on the co-ordination of this 'other safety communications' workstream on behalf of all ALB's. There is also a link between what the future CAS looks like and creating the correct platform. JB asked to be involved in the working group.

Action: NW to send out proforma to all NaPSAC members to repeat the earlier assessment of their remaining current CAS communications that would not meet NatPSA threshold and whether an alternative communication route is already available for these in advance of a full plan for 'other safety communications'.

Action: GT to set up "other communications" working group and report back to the next NaPSAC meeting.

6. The Central Alerting System – Paper on proposal to develop new CAS from MHRA

Paper presented by GT.

MHRA still have questions that need to be answered and do not have enough robust information to provide the committee with a robust paper on what the different options may look like.

MHRA are working to provide an options paper for the next NaPSAC meeting in April which will include any associated costs and anticipated timelines which will allow for some more considered decisions to be made.

GT noted that in a previous meeting PS flagged that from a DHSC perspective this was something that might go into the spending review. Questioned whether there were timings around this or whether there would need to be a consensus that the cost would be shared equally. AF commented that we had previously agreed a new system was necessary and that funding would need to be agreed.

PS will flag with finance colleagues at DHSC.

MP suggested that they (NHS Digital) would be interested in getting involved in the development of a new system.

Action: GT to link in with MP re system design for a replacement for CAS and to PS on funding needs

7. Remit document discussion

The remit document has been updated following feedback. There remains a number of areas for partnership working – these will need to be discussed each time an issue arises in order to quickly decide who takes the lead on any given alert and who will co-badge to ensure these issues are not lost in the system.

Action: All ALBs to review the remit document and identify whether these are genuine partnership areas or whether they can be allocated to individual organisations' remits.

As DHSC medication supply and device supply are being accredited separately, these will need to be shown separately on the remit document.

Action: NW to separate medication supply and devices on the remit document.

Action: KM & DW to review remits and update via NW.

Action: MP and GT to arrange a time to discuss the changes in medical devices, and feedback that information to NW so that the remit document can be updated before the next meeting.

SD (Scotland) that the document reflects the appropriate wording which includes the devolved administrations.

FH highlighted that for some alert issuing bodies their remit is only England, and each DA's endorsement gives the alert a remit to their nation. Only if all three DAs decide to do so is there a UK-wide application. As the alert originator cannot issue an alert which directs the NHS in any of the DAs wording will need to be carefully considered.

Action: NW to amend language in the remit document to include devolved administrations.

8. Audit process

Following on from conversations at the last NaPSAC meeting around how we give assurance in between cycles of accreditations, work has started to identify how we create a process, that is not too bureaucratic and onerous, to deal with issues with NatPSAs as they arise, or to give assurance that the criteria is being followed.

AE (Wales) suggested in the interest of different agencies continuing to learn from one another a peer process where alerts are periodically reviewed could be developed.

GT commented MHRA are already exploring peer review internally across the organisation and there would be an opportunity to partner up across ALBs for a light touch process.

Agreement that this could be a self-declaration, by way of a statement of intent document signed off by a senior executive within each organisation, however responding to concerns with individual alerts would need to be a different process to ensure we are able to react quickly to issues as they arise.

AF and TB both commented that this should also be used as an opportunity to learn and that this may include reissuing alerts if they were found to not have been clear and specific enough.

Action: NW to set up a meeting to explore audit options and bring proposals to next NaPSAC meeting for sign off.

9. Alerts and private healthcare providers

The committee had a discussion on how to ensure that independent and social care providers have access to alerts and are taking action on them so that they can be held to account in the same way that an NHS provider is.

TB reminded the committee that in England, CQC regulate all health and social care including independently provided health and social care and therefore it is important that our regulations and fundamental standards work across the board.

PS confirmed that there is a national body for private healthcare- Independent Healthcare Provider Network (IHPN) and there is ministerial interest in assisting the independent sector to improve safety and quality and to look at ways that the NHS and independent sector can work together. This falls into context with the Paterson Inquiry Report which will be published shortly, and the government will be expected to respond to the recommendations following that report.

It was agreed that as long as there was a mechanism whereby the independent sectors could access these alerts then CQC could regulate them. Any new system would need to be able to target alerts down to specific groups and across any sector.

Moving forward we should ensure any new system has the ability for all providers to connect and make sure communications can be targeted. As this system is designed, we need to involve the independent sector as well as social care providers in the process.

10. AOB

No other business

Date of next meeting is the 6th April 2020, from 13:30 to 15:30

Action Log		
Action	**Who by**	**Completed**
1. CT to arrange a meeting with NHS Digital	CT	
2. CT to arrange a meeting with Public Health England	CT	
3. AE/NW to explore a process for what a light touch accreditation may look like for the devolved nations where a NaPSAC accredited Alert has had minor amends and reissue	AE/NW	
4. NW to send out proforma to all NaPSAC members to repeat the earlier assessment of their remaining current CAS communications that would not meet NatPSA threshold and whether an alternative communication route is already available for these in advance of a full plan for 'other safety communications'	NW/All	
5. GT to set up "other communications" working group and report back to the next NaPSAC meeting – 06/04/20.	GT	
6. GT to link in with MP re system design for a replacement for CAS and to PS on funding needs	GT	
7. All ALBs to review the remit document and identify whether these are genuine partnership areas or whether they can be allocated to individual organisations' remits.	All	
8. NW to separate medication supply and devices on the remit document	NW	
9. KM & DW to review remits and update via NW	KM & DW	
10. MP and GT to arrange a time to discuss the changes in medical devices, and feedback that information to NW so that the remit document can be update before the next meeting on the – 06/04/2020.	MP & GT	
11. NW to amend language in the remit document to include devolved administrations.	NW	
12. NW to set up a meeting to explore audit options and bring proposals to next NaPSAC meeting for sign off – 06/04/2020	NW	
13. To invite an observer from the devolved nations to the next credentialing panel that involves a UK wide body.	NW	
14. To check any other points where the NaPSAC criteria need a minor change in language to avoid direct reference to England.	NW	
15. To work with members to identify suitable time lines with members to apply for accreditation.	NW	Ongoing
16. NaPSAC members to provide contact details for their comms team.	All	