NHS Patient Safety Strategy Oversight Committee
(SOC) Meeting
07 September 2021

Meeting Notes

Present

Chair: National Director of Patient Safety
Patient safety partner
Patient safety partner
Deputy Director of Patient Safety (Policy and Strategy) NHSE/I
Head of Patient Safety Policy and Partnerships, NHSE/I
Deputy Director of Patient Safety (Insight) NHSE/I
Medical Examiner Policy and Programme Lead NHSEI
Head of Patient Safety Cross-system development NHSE/I
Clinical Fellow, AHSN & NHSEI
Head of Patient Safety Improvement Programmes NHSE/I
Senior Nurse Advisor, NHSE/I
Head of Nursing and Midwifery/ HEE, South West
Clinical Improvement Director, NHSE/I
Deputy Director of Patient Safety (Mission 4), NHSX
Quality, Transformation and Patient Safety Lead HEE
Business Manager, NHSE/I

Apologies

Chief Nursing Information Officer (CNIO), NHSX
National Medical Examiner, NHSE/I
Deputy Director – Patient Safety, Maternity & Investigations, DHSC

1) Welcome and Introductions

The chair welcomed everyone to the meeting and everyone gave a brief introduction of themselves. In particular the new Head of Patient Safety Cross-system development NHSE/I, who has recently started in post and the newly appointed Clinical fellow to the NHS National Director of Patient Safety, were welcomed.

2) SOC notes and actions from the last meeting

The notes of the June meeting were approved and recorded as accurate by SOC. Actions from the last meeting were reported on:

Actions:

- **Carried over from June meeting: The National Patient Safety Team to recruit third Patient Safety Partner (PSP) to SOC. This action is ongoing with the process of recruitment to be taken forward this month of September**

- **Carried over from June meeting: NHSE/I to explore inviting an additional PSP as an observer of SOC in the interim until the recruitment of a third PSP is complete. This action is ongoing, and the committee will take this forward with the interest of PSPs requesting to attend SOC as an observer.**

3) Overview of strategy implementation status

The overview report was presented.

Implementation Milestones since June 2021:

- The replacement for NRLS and STEIS was formally launched on 19th July. This is a major milestone in the implementation of the strategy. The two systems are still going to be run in parallel, with a phased handover between them to maintain the existing level of reporting as far as possible.

- The Framework for involving patients in patient safety was published on 29th June. A Patient Safety Partners (PSPs) working group was established and the first meeting was held in August to identify how to further support implementation of the framework.

- A high profile symposium for Patient Safety Specialists was held in July with speakers including Don Berwick. This session marked the first in a series of sessions with expert speakers that are being brought in to speak to the PSS community. Next week Professor Charles Vincent will be speaking to the PSSs.

- A significant package of work to analyse and make recommendations for addressing inequalities in patient safety was completed by the National Director of Patient Safety's previous clinical fellow in July 2021. This will inform further work on addressing safety inequalities and several academic publications are expected to come out of this report.

Discussion:

- A question was raised regarding patient involvement in the work to implement the Framework for Involving Patients in Patient Safety. It was confirmed that the team are working in partnership with PSPs within the recently set up working group. Work is also ongoing with PSSs to collectively support further implementation via an improvement approach.
- SOC enquired whether the report on inequalities in patient safety could be shared with the group. The chair agreed that several documents can be shared. It was agreed for the Head of Patient Safety Cross-system development to share both presentations with PSP and wider committee.
- SOC congratulated NHSE/I on the launch of the Learning from Patient Safety Events (LFPSE) Service and enquired if there had been any feedback since the launch the new service. In response it was stated that feedback is being provided constantly. Issues arising in relation to oversight of reporting activity at a provider level, which is being resolved with a rapid piece of work underway with colleagues from wider NHSE/I teams to ensure appropriate linkage of provider systems via ODS codes. This will then ensure appropriate permissions and access are in place.
- A Senior Nursing Advisor introduced himself (attending in place of the previous Nursing Directorate committee member) and discussed the work that he is

involved in and enquired if there are any patients on the committee and to what degree of involvement CQC has in the delivery of the Strategy. The chair confirmed that there are patients on the committee and asked them to introduce themselves and identified that CQC is very much involved in the work.
- Both PSPs introduced themselves and one offered to have a conversation outside of the meeting, which was warmly welcomed.
- The chair also reiterated the need to recruit a third PSP, which is underway

Action:

- **NHSEI to summary documents from Patient Safety Inequalities in Healthcare research with PSP - Completed**

Insight

In addition to the launch of the LFPSE service described earlier, the following progress was noted:

- Patient Safety Measurement: Work to align measurement principles is ongoing with support from NHSE/I Single Oversight framework team.
- PSIRF: The new framework which will replace the serious incident framework is being tested by 14 early adopter organisations. Early adopters have provided positive feedback, but also report finding implementation of the new framework to be very challenging due to issues with capacity and resourcing related to COVID response.

Involvement

In addition to the publication of the Framework for involving patients in patient safety described earlier, the following progress was noted:

- Patient Safety Specialists (PSS): There are currently 733 registered PSS from 343 organisations with an estimated 97% coverage of what is expected. The current challenge is building, maintaining and improving engagement with this cohort of people.
  It was brought to the attention of the committee that work is ongoing with PSSs in CCGs and ICSs to understand their role. It was noted that most of the work that has been done with PSSs to date predominantly focuses on Provider PSSs, rather than those working in CCGs/ICSs. An initial meeting took place last week to explore this in more detail and to look at providing more clarity on expectations.

Improvement

In relation to the strategy improvement programmes, the following progress points were highlighted:

- Mat/Neo Safety Improvement Programme: The perinatal optimisation pathway is reaching fruition. Work is also ongoing around the Maternity Early Warning Score (MEWS) which is being developed as a prototype – testing and implementation plan for this is being refined including work with NHSX to scope a digital platform for the tool.
- Medication Safety Improvement Programme: Good engagement for this piece of work was reported. 80 Care Homes have engaged as programme participants with the support of patient safety collaboratives and 81 safety Champions from care homes have been recruited into programmes.
- Mental Health Safety Improvement Programme: Work is ongoing in relation to the guidance around assessment of ligature anchor points in in-patient services and other environmental self-harm risks with the CQC and the Mental Health Nursing Directors Forum.

- Adoption and Spread: Work is ongoing in relation to the development and delivery of Quality Improvement programmes to the COPD Audit programme
- Managing Deterioration Safety Improvement Programme: NatPatSIP and ManDetSIP are jointly writing a proposal paper outlining the need for a National Deterioration Strategy to provide direction to all related work. Work is also in development in relation to a National Paediatric Warning Score (nPEWS)

Improvement Discussion:

The Head of Patient Safety Improvement Programmes confirmed that a great summary was provided for the Deterioration work and mentioned that a lot of the deterioration work is focussing on early warning scores as a tool. It was also noted, that it would be best to contextualise this work against how much more work can be done in the prevention programme and if deterioration is identified early how can there be an early response and escalation.

A question was raised concerning the MH Patient Safety Networks, specifically what are their structures and what do they encompass? In response, it was stated that the networks are a standard model that have been used in other programmes. They act as a forum to bring together all stakeholders including PSPs across health and care settings to focus on issues at hand including national priorities or local patient safety concerns

Safety Culture and Systems
The following progress was highlighted:

- A Safety Culture programme group has been setup and met for the 1st time in July. Members include PSSs and PSPs with a total of 30 members. They are looking at co-producing a programme of work that will have meaningful impact on Safety Culture and help to tackle problems across the NHS. Work is scheduled to occur in Q3/Q4 2021/22 with a series of workshops and T&F groups to be delivered.
- Surveillance and Improvement through NHSE/I quality governance processes: The current focus is on creating guidance for Integrated Care Systems (ICSs) as the successor to CCGs and as a key part of the implementation of the Long-term plan. The team are working with the Quality Strategy team to ensure that Safety is appropriately represented within relevant quality sections of guidance and support provided for ICSs.

Safety Culture and Systems discussion:

- A query was raised in relation to the work around metrics and whether this was linked into the National Quality Board. It was confirmed that the work was linked. HEE also mentioned that their reporting tool is online for anyone to access.

Action:

- **Deputy Director of Patient Safety to confirm with Head of Patient Safety Policy if data from HEE tool currently feeds into the model hospital culture metrics, and if not, to urge that a dataflow is created**

4) Medical Examiners

An update on progress with the Medical Examiner system was provided. Highlights included the following:

- The Health and Care Bill is still making its way through Parliament meaning a statutory Medical Examiner system is anticipated from next year
- A letter was issued to the system on 08th June instructing Medical Examiner offices in Acute Trusts to start making plans for scrutinising deaths in all other areas.
- The has been quite a lot of engagement work in the background. This has highlighted challenges with wider implementation of the system for example in primary care where GPs have been involved in delivering the Covid response, and particularly vaccinations. There are several GPs who are Medical Examiners who are involved in talking about their experiences through a video and hopefully encouraging their colleagues to embrace the changes
- In relation to finances, Trust are reimbursed for Medical Examiner work with funding from DHSC.
- Trusts recently submitted data for April-June 2021 (quarter 1). The 129 medical examiner offices reported that 46,192 deaths were potentially available for scrutiny (a reduction from 74,033 deaths in January-March 2021). Medical examiners provided independent scrutiny of 38,343 deaths in the most recent period.
- Trusts' quarterly submissions for April-June 2021 also showed that
    - 12% of adults' deaths were referred to a coroner following medical examiner scrutiny
    - 12% of deaths scrutinised were referred for case record review
    - 372 patient safety incidents were notified after Medical Examiner scrutiny

Medical Examiner Discussion:
The chair identified that it was helpful to see the data on the number of cases being referred to coroners and structured judgement review but also raised a few questions regarding how many cases that go straight to the coroner are rejected and sent back and the outcome of this. A question was also posed regarding whether medical examiners could provide more details and data in addition to ONS figures. In response it was stated that the dataflow for referrals to coroners is still being refined, to ensure all cases referred are logged and contain the required detail. Data is collected on this and information is available on cases that come back to the Medical Examiner's office. It was noted that a digital system, has been in development for quite a few years. DHSC have appointed NHSBSA to take this forward – two Trusts are currently testing the digital system.

A question was raised in relation to deaths of people with learning disabilities and with severe mental illness – are there any statistics in terms of ethnicity? In response it was stated that there was very limited data and there isn't a reliable system for this. The current system is not suited for analysing different outcomes for different groups. Things that are currently monitored include for example, the urgent release of bodies for religious reasons by working with various groups. A paper has been published on this through the Royal College of Pathologists.

5) Patient Safety Syllabus
SOC received an update on the status of this work from HEE:
- An extra-ordinary meeting was held last week regarding a proposal by colleagues in the Academy of Medical Royal Colleges to optimise impact by combining the launch of Level 1 and 2 together in October 2021. Communications re the launch will follow a week later.
- In response the communications team are rejigging the timelines and the communication plan that that was being worked on.

- A joint presentation between HEE and NHSE/I will take place at Patient Safety Congress on 20th and 21st September
- In terms of developing a specification for the provision of level 3,4 and 5 to PSSs, the Academy will be working with a group of PSSs who have self-identified in helping with this work, but work has not started yet. The role of the group will be to specify syllabus content for levels 3-5 which will be delivered by an external provider.
- There was a discussion around funding for training PSSs and who will be picking up the cost for those that go forward to levels 3, 4 and 5. The Academy is also undertaking a piece of work to determine to which level PSSs should be trained.
- HEE flagged there are outstanding questions concerning when all cohorts of PSSs are trained, what happens to the training provider and will there be a continual pipeline of individuals coming through or how will this work?
- A paper was developed to look at mandatory training which was reported back at the last SOC meeting and one of the recommendations from the Academy was that this training should be made mandatory and at some point include it in the Core Skills Training Framework.

Patient Safety Syllabus Discussion

The chair provided feedback re the 1st Iteration of training by stating there is an anxiety around mandating training as this could not be universally very popular due to the busy schedule of people. In the long-term when its usefulness and relevance has been determined through feedback and it has been refined, then it can be worked upon to be made mandatory.

It was also mentioned that it's important to know when the next iteration would be out and to also think about engagement ensuring that relevant stakeholders are not missed.

There was also concerns around how can levels 3-5 be delivered differently without having to take individuals out of service for several hours. The role of simulation to deliver some of this training was also discussed.

6) NHSX Digital Clinical Safety

- The Digital Clinical Safety Strategy draft has been completed. This mirrors the Patient Safety Strategy as it is structured around the 3 I's: Insight, Involvement and Improvement.
- NHSX has been leading on this, but this a joint publication with NHS Digital; and NHSE/I. If all communication approval goes to plan, it should be published on 17th September for World Patient Safety day
- In relation to the consultation, engagement was expanded beyond Patient Safety specific stakeholders, and NHSX had further workshops with wider networks of industry, patients, academia, digital health organisations. Key priorities for the 3 I's were identified via these workshops. These workshops were very successful and were followed up by expert interviews and surveys to quantify priorities for inclusion in the Strategy now.
- This Strategy will be updated on an annual basis.
- During the consultation period some work was also done with the Patient safety Specialist network which was very helpful. There is an ongoing piece of work to determine how best it is to work with the PSS going forward.
- Bigger workstreams are now being stood up e.g. Digital safety training. A meeting with HEE will take place following this meeting to understand what the implementation of new material for this training will look like.

- The team intend to create a 'train the trainer' model around digital safety to be embedded across ICSs and regions. Best practice and safety guidance around Digital clinical safety is being pulled together.

Digital Clinical Safety discussion:

The chair noted that he was pleased to see the final draft of the strategy document and noted that two key elements are quite clear: digital tools being safe e.g. algorithms and how digital devices and approaches are used to make patient safety better.

A member of the committee enquired if primary care was involved in the consultations due to the diverse system and challenging patient safety concerns in the environment. In response it was confirmed that primary care was involved in the consultations.

Action:

- **NHSX to circulate to the committee the paper discussed today**
- **NHSX to circulate approved and signed off final draft of Digital Clinical safety Strategy to the Committee**

7) Risk register

SOC reviewed the risk register.

- There haven't been any significant movements on the risks over the last quarter. Most risks on the register are fairly low level and in hand.

Actions:

- **All programme leads to consider risk ratings and provide an update if required to keep document current and relevant**

Risk 3: Outstanding support from the regions have been provided in relation to the PSS agenda. They have been really engaged and have supported NHSEI national colleagues in creating networks and engaging with PSS at subregional levels.

Risk 8: The system is incredibly pressured, and staff are very stretched – it was agreed to elevate the likelihood and impact of this risk, whilst slightly revising it based on the sense of pressure in the system

8) AOB

The chair reminded the committee that the 17th September is World Patient Safety Day focussed on maternal safety. HSJ Patient safety Congress is on 20th -21st Sept

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9) Date of next meeting: 09/11/21 13.00 – 15.00

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- **NHSEI to provide the documents from the Patient Safety Inequalities in Healthcare research to members of SOC - Completed**
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