MEETING NOTES

Meeting:	NHS England Medical Patient Safety Expert Group		
Date:	Wednesday 24th June 2015		
Attendees:	Dr Mark Juniper (acting chair) Michelle Anstiss Catriona Blake Dr Mark Temple Dr David Smith Jenni Dewhurst Mike Surkitt-Parr Dr Susannah Long Vicky Voller Michelle Upton Diane Parsons (mins) By phone Julie Windsor Lorna Wilkinson Kevin Fox	**Apologies**:	Dr Linda Patterson (chair) Angela Brown Prof Huon Gray Ravi Mahajan JP Nolan Dr Nick Bishop Dr Paul Rylance Ruth Brown Susan Robinson Hilary Byrne Dermot Gleeson Dagmar Luettel Additional members who attend only when relevant items on agenda do not routinely need to send apologies

ITEM	KEY DISCUSSION	NUMBER IN ACTION LOG
Apologies:	As above The group welcomed new members Rachael Moses representing the Chartered Society of Physiotherapists and Lorna Wilkinson Director of Nursing Salisbury NHST, regional nursing representative and Wessex Patient Safety Collaborative. Dr David Smith has also replaced Dr John White as the representative of the British Thoracic Society.	
A	**Accuracy check of last meeting notes and approval** Amendment to item F, 'The NHSLA has pledged to support with a one – off payment of **up to** 10% reduction of their usual contribution to those organisations with safety plans which demonstrate a reduction in higher volume/ value claims' Meeting agendas and notes are now published on NHS England website http://www.england.nhs.uk/ourwork/patientsafety/patient-safety-groups/medical-specialties/ **Matters Arising.** National Safety Standards for Invasive Procedures (NatSSIPS) MT updated that final papers now going forward for endorsement by RCP	

	Update on Patient Safety Steering Group http://ww.england.nhs.uk/ourwork/patientsafety/patient-safety-groups/steering-grp/ Second Victims work now progressing with recent publications by Royal College of Physicians and Royal College of Surgeons. LP had highlighted preferred term of 'affected healthcare staff' **Action log.** Update on action 006: Velcro used to secure tracheostomies. It had not been possible to co-ordinate a webex meeting. MJ understood that NHS England was in the process of appointing a tracheostomy clinical lead. There would therefore be an alternative mechanism to progress this action and JWin agreed to make contact once this appointment was confirmed. Items closed. • Premature communication to relatives of failed resuscitations • Update of Key harms reported for Medical Specialties Data needs to be compiled to show themes of harm by specialty to facilitate a comparison. • Extravasation injuries in paediatrics – draft alert	Item 002
B	**Standing Item: Update on key harms**	
	Presentation circulated. Brief overview by JWin of the National Reporting and Learning System (NRLS) patient safety incidents resulting in severe harm and death in medical specialties (including A&E)- no, low or moderate harm not included (presentation circulated separately) Data shown as rolling quarterly and key harms themed by specialty. It was noted that compiling this data represents a significant amount of work for the Patient Safety Team therefore important that it is of use to members to help inform their work. The group was asked to consider if the 3 monthly data review is useful or is an annual review more meaningful. It is possible to generate individual data requests to support individuals work such as that by PR and the Renal Association. Discussion followed where all present found the data helpful but voiced some concerns that the large numbers of falls skewed the picture.. This might hide other important harms which are of lower volume. It was suggested that these could be separated out to allow a better focus on other issues. Additionally that these were self-reported therefore open to error. It was noted that more than 50% of severe and death harms shown occurred in people 65+ across all specialties. It was also noted that we are not looking at the more numerous lower harm incidents and consequently only a fraction of total patient harms reported are being reviewed and there was further potential to learn from near misses . Acute medicine is now a discrete recognised specialty and an area where a	

	significant number of patient safety incidents occur within the first 24 hours of care. The question was asked "How many deaths due to severe harm?" and would it be possible to extract this information from NRLS. This would represent a very large piece of work and most likely be very incomplete and it's unlikely providers have robust processes around updating initial reports. It would be possible to provide annual numbers of reported deaths.	
C	**Standing item: Patient story**	
	SL shared two recent and compelling patient stories concerning older frail patients that illustrated considerable difficulties relating to medications and discharge planning. One patient was re-admitted 3 weeks following discharge having re-started all pre- admission drugs because of errors on the discharge summary and another where the patients in hospital medications reconciliation had been in error and the drug list related to a different patient. A number of discussion points were raised: • Lack of continuity of junior medical staff is problematic • Junior medical staff writing discharge summaries can miss 'the bigger picture' … senior clinical supervision is vital. • A 'no blame' culture is vital to encourage reflections and lessons learned opportunities for learning. • Engaging with junior doctors in reflection on patient safety as part of their annual review can be a powerful mechanism for learning. • Review of electronic discharge summaries by consultants is a potential mechanism for ensuring accurate information is sent out to GPs following hospital discharge.	
D	**Standing Item: Alerts.**	
Alerts issued since last meeting: for information	MJ and members commented that were very pleased to have received letters of thanks from Mike Durkin following involvement in alerts. This was appreciated and was also useful for CPD evidence. **Risk of death or severe harm due to inadvertent injection of skin preparation** **Managing risks during the transition period to new LSO connectors for medical devices** All published alerts can be accessed on NHSE website http://www.england.nhs.uk/ourwork/patientsafety/psa/	
Alerts in draft stages: for information	**Patient Bounded Code List (PBCL) – standardization of pathology results terminology.** A wider consultation of the draft alert was proposed but stood down by the Patient Safety Steering group in favour of a focused consultation via Royal College of Pathology. Work is still moving forward and publication of	

	the alert is now to coincide with next PBCL coding update in September. **Emergency numbers standardisation in hospitals.** Following consultation thinking has moved away from an alert as being the best way to raise this issue again (there have been 2 previous alerts) and further more detailed work is being proposed to try and understand the issues for non-compliance better. A possible way forward is to link with the RCP deteriorating patient work stream.	
Brief update on alert issues discussed at previous meeting	**Harm from delayed updates to ambulance dispatch and satellite navigation systems** Working in partnership with ambulance services the alert is now in draft form. NRLS miniscope has identified 66 reports in an 18month period including 2 deaths and 3 delays in attending cardiac arrests.	
New Emerging issues	None discussed.	
E	**National Clinical Assessment Service: insight work in to unsafe practitioners.** **Vicky Voller, Head of Education & Learning, NHSLA**	
	Presentation circulated VV provided an overview of the work of NCAS, an organisation set up to provide resolutions over concerns about individual medical practitioners. Main responsibilities are to doctors currently but seeking to extend this to dentists and pharmacists. No capacity for nursing or allied health professions. Main points: 1,000 new cases a year Interventions can include case support, general and specific advice, assessment and intervention services, educational provider. Other functions include surveillance of referrals to pick up trends such as demographic associations with performance Can issue Health Professional Alert Notices (HPAN) to prospective employers if an individual is felt to pose a significant risk. 68% of persons referred return to work following most intensive intervention Discussion: Revalidation, is there something NCAS could do with 'early concerns' and 'back on track' programmes. Perhaps some guidance that could be included in annual appraisals. annual appraisals.	
F	**MBRRACE report on maternal deaths (non-obstetric causes)** **Michelle Upton, Pt Safety Lead Maternity & Newborn, NHSE**	
	Presentation circulated MU provided overview of this National Confidential Enquiry. Results identified deaths resultant from indirect causes (not obstetric) from previous existing disease or those that developed during pregnancy. Main points: There has been a 48% reduction in direct maternal deaths but indirect	

	deaths have doubled in last 10 years. Cardiac disease largest single cause but others include epilepsy and influenza • Need engagement to build standards to ensure early and consistent senior medical involvement both in antenatal period and acute phase if pregnant / recently pregnant patient presents as unwell • Recognise there is a distinction between physicians with an interest in obstetrics who run clinics and majority of units with less structured arrangements • Need to target less structured units • Need to identify a lead at the Royal College of Physicians (RCP) and liaise with Royal College of Obstetricians and Gynaecologists (RCOG) • Issue of epilepsy management being addressed by publication of guidance to be published in 2016. Discussion: Do we need to survey medicine/obstetric provision of services in localities? Since this report was published local scoping is underway so national picture should be straightforward to collate; caution needs to be exercised over interpretation of results as differing content over types and make up of local arrangements. Agreement that were key messages to be made about pre- conception counselling for many specialties. ***Action: MT agreed to raise this item forward to the RCP Patient Safety Steering Committee***	009
G	**Routine NHSE review of all PSEG's terms of reference etc – seeking your views - questionnaire**	
	In view of forthcoming Patient Safety Domain transfer of function to a new organisation as yet to be announced all PSEGs are conducting a short membership questionnaire in line with annual review of group's Terms of Reference. We would be grateful for your views particularly what works well and what you would like to see improved. Action: Questionnaire and TOR to be circulated with minutes ahead of discussion at next meeting.	
H **AOB**	1. CB presented this item earlier in the meeting. The Medicines and Healthcare Products Regulatory Authority (MHRA) are currently reviewing how they share information to providers. The old 'One Liners' being re-formatted into top tips by device type. The old style email format was previously circulated to Medical Device Officers however this route felt now to be too narrow, new style wants to focus on lessons learned and 'top tips'. Discussion followed: Has the Medical Device Officers Network been approached for	

	views? = yes. Is using the Central Alerting System (CAS) gateway a possibility? – Potential to get to many more relevant people. Have a representative group of providers been asked including trust governance leads, how they would like the information provided. Different formats such as leaflets, blogs, tweets etc were under consideration. 2. MJ proposed this future item on behalf of Angela Brown. Newcastle University Institute of Health and Society's ThinkSAFE project is an Academic Health Science Network (AHSN) backed evidence-based approach and toolkit to support patients and staff with patient involvement in their safety in hospital.	
Listing of proposed agenda items for next meeting.	1. Paul Rylance – Renal Patient Safety Website 2. Huon Grey & Kevin Fox –Atrial Fibrillation: diagnosis and screening, treatment plans, multiple co-morbidities and balance of risk v safety.	008
Listing of potential agenda items for future meetings	**Agree priority of proposed agenda items for future meetings:** i. Update on RCP 'second victims' when KS available to attend ii. Mike Durkin update on NHSE Patient Safety domain iii. Revisit 'duty of candour to colleagues' (obligation to highlight and raise learning opportunities) iv. Imperial to present on their approach to analysis and development of the NRLS v. Presentations from NHS England medication safety team (including allergy issues) vi. Update of Sign Up To Safety Campaign by Suzette Woodward (September meeting) vii. Any issue raised by the group viii. Volunteer for patient story for next meeting	
New publications to note and/or resources recommended at the meeting	None at present	
Dates of 2015/16 meetings	• Wednesday 30th Sept 2015 • Wednesday 9th December 2015 • Wed 23rd March 2016 • Wed 22nd June 2016 • Wed 28th Sept 2016	

	All meetings are 14.30 - 17:00 at Skipton House Please be advised that with regret and due to revised NHS England hospitality policy, refreshments are no longer provided for these meetings. It is advisable to arrive at Skipton House in plenty of time to get signed into the building etc to allow a prompt start at 2.30. Diary invitations have been sent out but members will receive reminders two weeks prior to the meeting with papers sent out one week in advance.	