Minutes of the Meeting of West of England Academic Health Science Network Patient Safety Collaborative Board
Tuesday 16 December 2014, 10am – 12Noon
Oasis Centre, Royal United Hospital, Combe Road, Bath

Attendees:
James Scott  Chair
Deborah Evans  Managing Director, West of England Academic Health Science Network
Natasha Swinscoe  Director of Development
Aileen Davies  Quality Manager, Seqol
Alison Moon  Transformation & Quality Director, Bristol Clinical Commissioning Group
Andrew Seaton  Director of Safety, Gloucestershire Hospitals NHS Foundation Trust
Ann Harding  Public Contributor
Anne Pullyblank  Clinical Director of Patient Safety
Bee Martin  Executive Medical Director, Weston Area Health NHS Trust
Cathy Howe  Patient Safety Programme Director
Christine Perry  Director of Nursing, Weston Area Health NHS Trust
Christopher Brooks-Daw  Interim Head of Clinical Governance, Gloucestershire Care Services
Dawn Clarke  Director of Nursing and Quality, Bath and North East Somerset Clinical Commissioning Group
Dina McAlpine  Interim Deputy Director of Quality and Patient Safety, Wiltshire Clinical Commissioning Group
Dr Emma Redfern  Associate Director for Patient Safety
Gill May  Executive Nurse, Swindon Clinical Commissioning Group
Dr Hein le Roux  Clinical Lead for Primary Care
Helen Blanchard  Director of Nursing & Midwifery, Royal United Hospital Bath NHS Foundation Trust
Hildegard Dumper  Patient and Public Involvement Manager
Joanna Parker  Public Contributor
Louise French  Head of Quality & Patient Safety, Wiltshire Clinical Commissioning Group
Dr Martin Jones  Chair, Bristol Clinical Commissioning Group
Nicole Casey  Head of Governance, South West Ambulance Service NHS Foundation Trust
Rosi Shepherd  Assistant Director of Nursing, Quality and Safety, NHS England
Sharren Pells  Assistant Director of Quality & Patient Safety, Swindon Clinical Commissioning Group

Apologies:
Aileen Fraser  Clinical Director, Bristol Community Health
Alison Robinson  Nurse Director & Head of Quality and Safeguarding, South Gloucestershire Clinical Commissioning Group
Anne Reader  Head of Quality (Patient Safety), University Hospitals Bristol NHS Foundation Trust
Claire Madsen  Deputy Clinical Director, Bristol Community Health
Diane Blake  Operational Co-ordinator, Seqol
Jacqui Chidgey-Clark  Director of Quality and Patient Safety, Wiltshire Clinical Commissioning Group
Janina Cross  Informatics Lead, West of England Academic Health Science Network
Jenny Winslade  Executive Director of Nursing and Governance, South West Ambulance Service NHS Foundation Trust
<table>
<thead>
<tr>
<th>Name</th>
<th>Position/Role</th>
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<tbody>
<tr>
<td>Kay Houghton</td>
<td>Senior Quality Development Manager, Gloucestershire Clinical Commissioning Group</td>
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<td>Liz Fenton</td>
<td>Director of Nursing, Gloucestershire Care Services NHS Trust</td>
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<td>Marion Andrews-Evans</td>
<td>Director of Nursing &amp; Quality Lead, Gloucestershire Clinical Commissioning Group</td>
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<td>Sally Ashton</td>
<td>Clinical Continuous Improvement Lead, 2Gether NHS Foundation Trust</td>
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<td>Tricia Woodhead</td>
<td>Associate Director for Patient Safety</td>
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<td>Dr Charles Buckley</td>
<td>GP &amp; CCG Board Member, Gloucestershire Clinical Commissioning Group</td>
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<td>Kate Thomson</td>
<td>Bristol Community Health</td>
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<td>Liam Williams</td>
<td>Interim Chief Nurse, North Somerset Clinical Commissioning Group</td>
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<td>Lisa Cronan</td>
<td>Professional Lead for Nursing, Sirona Care &amp; Health Community Interest Company</td>
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<td>Lisa Harvey</td>
<td>South Gloucestershire Clinical Commissioning Group</td>
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<td>Penny Brown</td>
<td>Chief Executive, North Somerset Community Partnership</td>
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<td>Penny Smith</td>
<td>Director of Quality, Nursing &amp; Therapies, North Somerset Community Partnership</td>
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1. **Welcome and Introductions**

James welcomed all to the meeting, introductions were made and apologies noted. Ann Harding and Joanne Parker were attending the meeting for the first time as the new Public Contributors for Patient Safety.

2. **Actions from the Previous Meeting, 9 September 2014, and Matters Arising Omission from previous minutes:**

The Patient Safety newsletter was finalised and circulated to all.

Lindsay Scott who is the lead for Sepsis was unfortunately not able to join the Board meeting; however Deborah is meeting with Lindsay and colleagues at Bath Wiltshire and Gloucestershire area and an update on the development of the sepsis workstream will be included for the next Board meeting.

Cathy highlighted a presentation delivered from Imperial Healthcare, which identified the support across the whole system, with resources and interest. The workshop identified that Sepsis is an area that could sit neatly across the whole system.

3. **Matters for Discussion**

   **3.1 Patient Safety Programme Update**

Deborah explained that going forward; the programme update will be in a format of a newsletter, and key points highlighted from the latest edition:

- A delegation of 15 attended the National Patient Safety Collaborative launch; a team photo will appear in Decembers Patient Safety newsletter.
- The Quality Improvement team helped run an event on 14 December 2014 at Bristol Golf Club which trialled an approach to outpatient and public involvement representation. The event was led by Hildegard Dumper.
- Anne Pullyblank recorded a video in which she explained the rationale behind having standardised documentation as part of a patient safety programme. People were asked to vote on what they thought and the results were very positive.
- Anne Pullyblank announced the Emergency Laparotomy bid which would be funded by the Health Foundation. The bid was submitted jointly with KSS and Wessex Academic Health Science Network’s. All Academic Health Science Networks were invited for an interview on 27 November. The bid was to scale up patient safety work on Emergency Laparotomy, where a small study had been conducted with four hospitals where a care bundle was applied to Emergency Laparotomy patients and reduced mortality in all four hospitals. The bid was to scale this throughout the three Academic Health Science Network’s in order to improve the outcomes for patients having an emergency laparotomy. Anne reported that the interview went well, with positive feedback received.

Anne to announce the results of the interview process once known

**Action: AP**

   **3.2 End of Programme Review of Safer Care South West**

Cathy announced the last of the three pre-planned Patient Safety workshops, Reducing Harms for fall which was held at Taunton Racecourse, ran successfully, with 90-100 delegates attending. Cathy Howe reported that there were representatives from all three Academic Health Science Network’s; work presented throughout the day suggested that
reducing harms for falls had become more challenging. The delegates were asked to think about what they would do if there were no more collaborative events looking at falls. Universally, delegates said that if there were no more events they would continue the work and try and keep in touch with other people. Cathy highlighted to delegates that with sufficient interest and enthusiasm West of England Academic Health Science Network would consider continuing to help and support Reducing Harms for fall.

4. Matters for Decision
Deborah outlined the draft initial priorities to the Board members.

4.1 Draft Patient Safety Initial work programme

Cathy briefly explained the basic approach to the report was to interview key individuals who were involved in the leadership of Safer Care South West Programme, responses were positive and all were happy to participate. The report was based on those interviews and did not consider the quantitative data entered during the programme onto the extranet.

Cathy explained that the qualitative post-programme review of the Safer Care South West programme was to enable the West of England Academic Health Science Network to retain the best of the programme and learn from aspects that did not go so well.

The main findings of the paper included:

- Turnover of leaders, staff, and system change which affected continuity.
- The programme raised the profile of patient safety through building a network of people and organisations, with limited financial investment compared to some other programmes.
- Since the launch of the programme in 2009, significant improvements across the region have been reported, including a reduction in adverse events.

The report captured the external view of the programme and the importance of keeping and developing the programme. Cathy referred to the recommendations for the new Patient Safety Collaborative which included the need for incorporating leadership, boundaries priorities and for the programme to be driven by evidence and evaluation.

Hein Le Roux inquired, that as a GP, he would be interested to know who attends the workshops, and Anne Pullyblank explained that the workshops are secondary care focussed. Hein explained that there was an opportunity here to arrange workshops for GP’s or jointly with Primary Care.

James recommended tracking the improvements by reviewing the work carried out by each of the patient safety workstreams.

4.1.1 Early Warning Score

Anne explained West of England Academic Health Science Network’s proposal for Early Warning Score which is to develop this method which will be utilised across the whole system. Using standardised tools and offering training, the Early Warning Score chart was a good way to progress standardising process across the whole system.

Anne highlighted the benefits of the National Early Warning Score which is a standardised system across care which has been adopted by acute organisations. Anne suggested that in order to meet the workstream aims, it would be crucial to ensure the National Early Warning
Score across the system incorporating the wide spread use of standardisation tools and offering training on human factors issues.

### 4.1.2 Proposal for the development of a Primary & Community Care Workstream

Hein briefly ran through the purpose of the Primary and Community Care workstream and how it is proposed to be developed and act as an expert group for Primary and Community services.

The Primary and Community Care sub-group is holding an inaugural workshop on Wednesday 4 February 2015 with key people to agree a direction of travel for the workstream. Hein explained the overall aim of the day would be to generate engagement and develop areas so the group could understand the patient safety issues facing primary and community organisations.

Invitations have been sent to providing trusts to request support; Natasha welcomed all Board Members to attend the workshop on Wednesday 4th February 2015.

#### 4.1.2.1 Primary & Community Care sub-group Terms of Reference

The Board members agreed to sign off Terms of References for Primary and Community.

### 4.1.3 Human Factors Training

Cathy explained how the workstream is funded by Health Education South West, and focused around three areas of training. The initial human factors training will be piloted in Sirona, Bath and North East Somerset and will be directed at bands 1-4. The second phase of training will be focussed at band 5 supervisors who will be trained to ensure that bands 1-4 are working in a way that supports their learning from the Human Factors Training.

The continuation of Human Factors training will also include patients and lay people, with a view to develop patient leaders in patient safety. The cost of evaluating for this training has also been factored in.

Helen Blanchard advised further training to board level, providing briefing papers so everyone at every level is aware of human factors and that understanding is universal.

Deborah highlighted the importance of empowering staff to change and to ensure that change leads to improvement. Funding will be spread across to train staff and lay people and provide work plans so the commitment is understood.

James stressed the importance of continued engagement with member organisations, as most organisations are signed up to safety (or in the process of doing so), they need to be kept informed of developments within the Patient Safety workstreams.

### 4.1.4 Medicines Optimisation

Deborah explained that Medicines Optimisation is one of the workstreams from Safer Care South West. There has been dialogue regarding workstreams that should be progressed and workstreams that should cease. It was agreed to continue Medicines Optimisation. Deborah will support Stephen Brown, Director of Pharmacy from University Hospitals Bristol on this as priorities are yet to be defined on this workstream. In order to deliver this work a working group will need to lead the work and apply improvement methodology across the range of healthcare sectors.
5. Matters for Information

5.1 Emergency Laparotomy

Anne briefly ran through the paper and explained that the Emergency Laparotomy work wouldn’t start until the mid-end of 2015 because a clinical trial is still running. The initial six months will include setting up the programme.

5.2 Mental Health Collaborative

Natasha advised that there was no paper for the Mental Health Collaborative update, but explained that the Mental Health Collaborative involves the West of England, Oxford, South West, Wessex and Kent Surrey and Sussex Academic Health Science Network’s in south England. The workstream will be led by Shaun Clee from 2Gether Trust and Helen Smith from Devon Partnership NHS Trust. The first initial Mental Health Collaborative meeting will take place on Friday 16th January 2015. Natasha noted that Academic Health Science Networks have been involved with the Mental Health Collaborative historically, and are continuing to be supportive for Mental Health Trusts to work collaboratively.

Natasha will update the Board following the next meeting of the Mental Health Collaborative.

Action: NS

6. Any other Business

Deborah announced the forthcoming Patient Safety and Quality Improvement official launch event which will be held at the De Vere Hotel, Swindon on Thursday 16 April 2015. All Board members were welcomed to attend.

Deborah also highlighted the Early Warning Score workshop which is taking place on Thursday 5 March at the Holiday Inn, Filton Bristol.

The details of upcoming Patient Safety Board meetings were noted, meetings will now occur bi-monthly.

7. Date of Next Meeting

Tuesday 12 March, Dartington Suite, University of the West of England, Bristol