Minutes of the Meeting of West of England Academic Health Science Network Patient Safety Collaborative Board
Tuesday 9 September 2014, 10am – 12Noon
Oasis Centre, Royal United Hospital, Combe Road, Bath

Present:
James Scott Chair
Deborah Evans Managing Director, West of England Academic Health Science
Natasha Swinscoe Director of Development
Dawn Clarke Director of Nursing & Quality, Bath and North East Somerset Clinical Commissioning Group
Jacqui Chidgey-Clark Director of Quality & Patient Safety, Wiltshire Clinical Commissioning Group
Hildegard Dumper Patient and Public Involvement Manager
Melanie Rogers Head of Clinical Governance, Gloucestershire Care Services NHS Trust
Steven Kibble Head of Governance & Patient Experience, Weston Area Health Trust
Sally Ashton Clinical Continuous Improvement Lead, 2Gether Foundation NHS Foundation Trust
Rob Nicholls Deputy Director of Nursing (for Penny Smith), North Somerset Clinical Partnership
Anne Reader Head of Quality & Patient Safety, University Hospitals Bristol NHS Trust
Kay Haughton Senior Quality Development Manager, Gloucestershire Clinical Commissioning Group
Cathy Howe Patient Safety Programme Director
Janina Cross Informatics Lead
Lisa Cronan Professional Lead for Nursing, Sirona
Andrew Seaton Director of Patient Safety, Gloucestershire Hospitals NHS Trust
Diane Blake Professional Lead, SEQOL
Kate Thomson Quality & Patient Safety Manager, Bristol Community Health
Martin Jones Chair, Bristol Clinical Commissioning Group
Anne Pullyblank Clinical Director of Surgery, North Bristol NHS Trust
Lisa Harvey Designated Nurse Safeguarding Children/Deputy Nurse Director, South Gloucestershire Clinical Commissioning Group

Apologies:
Alison Moon Transformation & Quality Director, Bristol Clinical Commissioning Group
Alison Robinson Nurse Director & Head of Quality and Safeguarding, South Gloucestershire Clinical Commissioning Group
Bee Martin Executive Medical Director, Weston Area Health NHS Trust
Christine Perry Director of Nursing, Weston Area Health NHS Trust
Claire Madsen Executive Nurse, Deputy Clinical Director, Bristol Community Health
Gill May Executive Nurse, Swindon Clinical Commissioning Group
Helen Blanchard Director of Nursing & Midwifery, Royal United Hospital Bath NHS Trust
Jenny Winslade Executive Director of Nursing and Governance, South West Ambulance Service NHS Foundation Trust
Liz Fenton Director of Nursing, Gloucestershire Care Services NHS Trust
Marion Andrews-Evans Director of Nursing & Quality Lead Gloucestershire Clinical Commissioning Group
Nicola Casey Head of Governance, South West Ambulance Service NHS Foundation Trust
Lindsey Scott Director of Nursing & Quality, Bristol, North Somerset, Somerset and South Gloucestershire Area Team
1. Welcome and Introductions
   James welcomed all to the meeting, introductions were made and apologies noted.

2. Actions from the Previous Meeting, 19 June 2014, and Matters Arising
   Omission from previous minutes:
   Anne Reader did attend the previous meeting and the minutes will be amended to reflect this.

   Matters Arising
   The funding streams for Patient Safety were clarified – a proportion comes from the Academic Health Science Network and NHS IQ and it was noted that the RUH retains the money used for the Safer Care South West programme. This will fund the workshops that are ongoing under that umbrella.

3. Matters for Discussion
   3.1 Patient Safety Programme Update / Managing Director’s Report
   Deborah explained that she completed her report in the format of a newsletter and highlighted the key points:
   - The evaluation of the Safer Care South West programme had commenced. The report will come to the Board once complete;
   - In collaboration with Kent, Surrey and Sussex and Wessex Academic Health Science Networks, the West of England Academic Health Science Network has applied to the Health Foundation funding for scaling up improvement – this will be for Emergency Laparotomy. The bid has been shortlisted and the process continues to progress. This may be commenced as a workstream in its own right, regardless of whether the bid is successful.
   - A workshop for Quality Improvement leads was held on 31 July. The workshop reviewed elements that would be useful to offer on a West of England-wide basis to support capacity for Quality Improvement and Patient Safety.
   - Health Education South West had given the Academic Health Science Network £250k for Human Factors training. This will be directed to community services and primary care services and will be piloted in the Bath and North East Somerset area.
   - Deborah welcomed Cathy Howe to the Board; Cathy starts as the Patient Safety Programme Director on 15 September and would work with Natasha Swinscoe to take this forward. Discussions were continuing with NHS England with regards to available resources.
   The newsletter will be finalised after the meeting and circulated.  
   Action: DE

   3.2 Membership – NHS England Representation
   Further to a discussion at the last meeting, concerns were raised with regards a gap in NHS England representation specifically around specialised commissioning and Patient Safety. Deborah discussed this with Anthony Farnsworth who nominated Lindsey Scott, Director of Nursing & Quality, Bristol, North Somerset, Somerset and South Gloucestershire Area Team. Unfortunately, due to other commitments, Lindsey was not able to attend today’s meeting.
Further to the ongoing NHS England Realignment, Bath, North Somerset, Somerset and South Gloucestershire Area Team would now be realigned with the Thames Valley and it was agreed that there should be representation from that area team on this Board.

3.3 Proposal for the Development of a Sepsis Workstream

Natasha briefly ran through the paper and explained that this would build on the existing work from the Safer Care South West programme. The Board was asked to approve the setting up of an expert group to develop the Patient Safety work programme, using a driver diagram approach and the group would also scope how improvements could be achieved. The expert group would also include patient representatives. The paper proposed that the group would be led by Lindsey Scott and would report back to the Board with progress. Jacqui Chidgey-Clark advised that work had begun on completing the second return for Sepsis 6 and collaborative working continues between Wiltshire, Bath and North East Somerset and Swindon. It was essential to ensure the link to all organisations is maintained and it was stressed that the Academic Health Science Network was supporting this work, rather than leading. It was also agreed to include representatives from one or two acute Trusts and Andrew agreed to co-ordinate this. It was also agreed that South West Ambulance Trust should be included on this group, in addition to community services.

Action: AS

4. Matters for Decision

4.1 Patient Safety: Setting Our Approach

Anna Burhouse, who produced this paper, was unfortunately not able to attend to present the paper but it set out the intended approach. Anna’s brief to produce the paper was to ascertain evidence about what we know works and how this can be used for patient safety. This was the final draft but comments were welcomed and a shorter working version of the paper would also be produced. Deborah stressed the importance of evaluation, which was not included, in the paper but was a key point. Cathy Howe will also assist with the evaluation process.

The following comments were made:

- How would capability and culture be measured as questionnaires may be too simplistic. The NHS has a duty of candour and this implies a change of culture for the whole NHS. How can this be made a reality, particularly as generally, patients are unaware of the harm that can be caused to them. The Guiding Principles for the Patient Safety Collaboratives included a couple of key points on this subject.

- How would the shared database look? One difficulty with regards to the database is the uploading of data and as measurement is key, a different way of doing this needs to be defined; the Extranet that was previously used was not completely successful. It would be crucial to benchmark and to also share progress. Janina Cross, Informatics Lead for the West of England Academic Health Science Network, would assist with this strand of work.

- Safety issues regarding gaps in organisations - it would be useful to get a steer on what we would like to see for all organisations.

- It must have a whole-system approach, including hospices, social care and community interest companies.

- It must fit with the drive of the clinical commissioners so as to address any gaps.
- Need to include a section on sustainability.
- With regards commissioning, it needs to support improvement methodologies rather than just the performance monitoring.
- A reference to ‘Sign Up To Safety’ would be included in the final version.

Deborah would pass all comments to Anna to produce a final version, in addition to a summary.

**Action:** AB

### 4.2 Patient and Public Involvement Strategy for Patient Safety

Hildegard ran through the paper, which included the proposed approach, prior to its wider circulation to the patients and public.

Hildegard explained that the West of England Academic Health Science Network already has two Patient and Public Involvement members who advise the Board on its way forward; this was also part of a collaborative strategy group with the CLARHC. It was the intention to have two members specifically to sit on this Board and a recruitment process is currently underway for Patient and Public Involvement representatives to participate in Board meetings, which may be different to attendance at discussion groups. It was hoped to confirm the appointments by Monday 15 September.

With regards the approach, Hildegard is intending to move towards co-design; working with members of the public to design materials, devise training etc and the paper also includes an outline training plan. A reference group was also being considered.

Hildegard asked if Board members would be willing to take it to their Patient and Public Involvement leads to test out and she would also take it to the Patient and Public Involvement Strategy Group for comments. In addition, Hildegard was undertaking scoping work with other Academic Health Science Network Patient and Public Involvement groups. Comments on the paper were welcomed.

- Was the paper being taken to carers groups? Hildegard confirmed this would be addressed by way of capacity building and explained that Patient and Public Involvement representatives would visit carers groups. Hildegard would include more detail in this regard.
- The paper needs to be more explicit with regards the human factors element; this would link to the human factors training in Bath and North East Somerset, which would also cover Patient and Public Involvement. This would also be evaluated to ascertain whether an impact has been made.
- Deborah inquired as to the extent to which organisations have Patient and Public Involvement in their patient safety work and how we can support organisations. James referenced Mersey Care NHS Trust who do not make any decisions without real public involvement.
- Clarity with regards involvement of representatives was needed as it had been challenging within some organisations so additional support would be greatly welcomed. Training for the representatives would also need to be very detailed so roles and responsibilities were very clearly defined.
- Martin Jones referred Hildegard to the Crisis Concordat, which had some areas of good work which could be used as examples.

The paper would be updated and brought back to this Board.

**Action:** HD
5. Matters for Information

5.1 National Patient Safety Collaborative - 14 October Launch and Guiding Principles

The Guiding Principles set out the expectations for the Patient Safety Collaboratives and Natasha and Cathy would bring back to the next meeting an update of the current position against the first and second assessments.

Action: NS / CH

The Guiding Principles ask that Patient Safety Collaboratives run programmes to improve leadership and measurement for patient safety and two areas for focus was Sepsis and measurement for leadership and how to progress these further. Natasha advised that work is underway to map what was already in place and, in conjunction with the evaluation of the Safer Care South West programme, see how this maps against the table of priorities shown in the Guiding Principles and the proposed areas for progress that this would generate. This would then form the basis of the Patient Safety work programme and must include:

1. Work that was evidence-based – what has been learned from Safer Care South West.
2. Work we have to do, as set by NHS England
3. Engaging with our member organisations to ascertain work they wish to progress; including liaising with staff at all levels.

At the next Board meeting in December, the proposed areas of work that have been identified will be filtered down to what was manageable and deliverable over a reasonable period of time. This work was to be signed off by December’s Board in order for the work to be commenced.

Action: DE / NS / CH

With regards the launch event, the West of England Academic Health Science Network have been allocated ten spaces and are currently oversubscribed. Additional places have been requested but if this was not possible, the list of those who would like to come will be reviewed and spaces will be allocated so as to ensure spread against the wider community. The Academic Health Science Network has also been asked to run two workshops at the launch.

5.2 Appointment of Clinical Director and Clinical Leads for Community and Primary Care

Interviews for the role of Clinical Director for Patient Safety were held on 8 September and James announced that Anne Pullyblank had been appointed into the role. Anne was congratulated on her appointment.

Deborah and Martin would interview for the Clinical Lead for GP services on 10th September, followed by further interviews on 19 September for the Clinical Lead for the Community Services role. These interviews would be undertaken by Deborah and Paul Jennings, Chief Executive, Gloucestershire Care Services NHS Trust.

6. Date of Next Meeting

Tuesday 16 December 2014, 10am – 12Noon, Dartington Suite, University of the West of England