NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	NHS Improvement Patient Safety Alerts and Never Events	**Date: 29/06/2018**
Prepared By:	Jackie Robinson, Risk and Assurance Manager	
Approved By:	Paul Moore, Director of Governance & Quality Improvement	
Presented By:	Paul Moore, Director of Governance & Quality Improvement	

Purpose		
To acknowledge the receipt of the letter from NHSI and advise the Board as to the current position at Sherwood Forest regarding the response to National Patient Safety Alerts and assurance processes regarding implementation.	**Approval**	
	Assurance	✓
	Update	
	Consider	

Strategic Objectives				
To provide outstanding care to our patients	**To support each other to do a great job**	**To inspire excellence**	**To get the most from our resources**	**To play a leading role in transforming health and care services**
✓	✓	✓	✓	✓
Overall Level of Assurance				
	Significant	**Sufficient**	**Limited**	**None**
		✓		
Risks/Issues				
Financial				
Patient Impact	Failure to implement alerts could result in patient harm			
Staff Impact				
Services				
Reputational	Failure to implement alerts or to close alerts on the system when not fully implemented could significantly impact on the reputation of the Trust.			

Committees/groups where this item has been presented before

N/A

Executive Summary

At the request of the Secretary of State for Health and Social Care, and following concerns about the continuance of some types of Never Event in the NHS in England, the Care Quality Commission (CQC) carried out a review of Never Event and safety alert implementation in a selection of NHS providers. Sherwood Forest Hospitals was one of those trusts selected for inclusion as the review coincided with the Trust's CQC inspection. This review took place during the CQC's recent well-led inspection in May 2018. The Trust received positive verbal feedback and understands that a report will be prepared by the CQC for the Secretary of State outlining the findings and areas for future learning. We also understand that the CQC's report will reflect the CQC's overall findings and not necessarily be specific to Sherwood Forest Hospitals NHS Trust.

On 1st June, NHS Improvement issued a letter to all Chief Executives, Medical Directors and Directors of Nursing. This letter highlighted issues regarding the governance of NHSI Patient Safety Alerts at some trusts; in particular concerns that in some trusts alerts are being recorded as 'action complete' when this may not be the case.

Two recent Patient Safety Alerts were tested by CQC: (i) NHS/PSA/D/2016/009 *Reducing the risk of oxygen tubing being connected to air flowmeters*; and (ii) NHS/PSA/RE/2016/006 *Nasogastric tube misplacement: continuing risk of death and severe harm.*

This paper takes the opportunity to assure the Board of Directors that these two alerts have been reviewed internally, and tested by CQC, and both alerts have been correctly actioned by the Trust. In addition, we use this opportunity to remind the Board of the governance arrangements in place for the management and oversight of safety alerts, and assurance risk as we go forward.

Whilst the index alerts tested by CQC inspectors were satisfactory at the time of inspection, we consider that there may be risk to assurance for some other alerts. We therefore advance in this paper a proposal for the Board to consider periodic testing of those alerts which may pose the greatest risk to board assurance. Such alerts would typically include those:

(i) where the alert requires that an action plan be developed, but does not specifically state the action plan must be implemented (a minority of alerts specify a requirement for an action plan to be implemented in order to close the alert on the Central Alert Broadcast System);
(ii) that span more than one division, where there may be difficulties associated with ownership and control; and
(iii) alerts that concern the application of clinical practice (how practitioners should act) that are 5 or more years since issue.

Introduction
The NHS Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety-critical information and guidance to the NHS and others, including independent providers of health and social care.

On the 1st June 2018 NHS Improvement circulated a letter to all NHS Trusts and NHS Foundation Trusts reporting that there had been evidence to suggest that governance arrangements regarding responses to NHSI Patient Safety Alerts may not be sufficient for assurance purposes (Appendix 1).

The letter focused on: (i) NHS/PSA/D/2016/009 *Reducing the risk of oxygen tubing being connected to air flowmeters*; and (ii) NHS/PSA/RE/2016/006 *Nasogastric tube misplacement: continuing risk of death and severe harm*.

16 trusts have reported incidents related to the unintended connection to an air flowmeter since this alert NHS/PSA/D/2016/009 was issued in February 2018. NHSI are concerned that the trusts involved may have confirmed to their board that all required actions in the alert had been completed on the CAS system when this may not have been the case.

NHSI have requested all trusts review their processes for compliance and, in any cases where incomplete actions were identified, arrange for the relevant status on the Central Alerting System (CAS) to be corrected.

GOVERNANCE OF CAS ALERTS AT SHERWOOD FOREST HOSPITALS

The Trust operates different pathways depending upon the type of CAS alert received. This is to ensure the relevant experts are in receipt of the alert rapidly and can initiate the requisite response promptly. Alerts are processed as follows:

- **Patient Safety Alerts** are received and reviewed by the **Risk and Assurance Manager** and assigned to an appropriate multi-disciplinary group or lead clinician for action as required. Implementation is overseen by Patient Safety & Quality Group (PSQG) and assured by Quality Committee;

- **Medical Device Alerts** are received and reviewed by the designated **Medical Devices Safety Officer (MDSO)**. Alerts are cross checked against the equipment inventory and assigned to an appropriate lead. Implementation of actions is reviewed by the Medical Device and Equipment Group, overseen PSQG and assured by Quality Committee;

- **Estates & Facilities Alerts** are received and reviewed by the Risk and Assurance Manager, who forwards them to the Head of facilities and estates and a named contact within Central Nottinghamshire Hospitals plc. These alerts are responded to by Central Nottinghamshire Hospitals (CNH). Implementation is monitored by the Estates Governance Group, overseen PSQG and assured by Quality Committee;

- **Drug Alerts** are received and reviewed by the **Risk and Assurance Manager** and assigned to the Medicines Safety Officer (MSO) in Pharmacy for action as required. Implementation is overseen by Patient Safety & Quality Group (PSQG) and assured by Quality Committee.

The Risk and Assurance Manager is the Trust's designated CAS Alerts Officer and is responsible for managing and co-ordinating the Trust's response to all CAS Alerts. Alerts that are relevant to the Trust, and require action to be taken, are added to the CAS Action Plan. This is maintained by the Risk and Assurance Manager within the Governance Support Unit (GSU).

The Action Plan, confirming which alerts have actions in progress, is distributed every month to all divisions and relevant corporate functions through established governance arrangements.

Alerts may be closed on the CAS system if all requirements of the alert are met, providing evidence of implementation has been provided. The GSU request and catalogue evidence before an alert is closed on the CAS. Alerts remain open on the Trust internal Action Plan until the Patient Safety and Quality Group is satisfied that all other actions (not specified in the alert) have been implemented.

Data showing the number of Patient Safety Alerts that are overdue for closure at the end of each month is collated on a monthly basis and provided to the Head of Information Services and incorporated into the Single Oversight Framework (SOF). **Note that this only applies to Patient Safety Alerts not all CAS Alerts, as per the requirements of the SOF guidance published by NHSI.** There are no alerts overdue for closure at time of report.

Any outstanding action in relation to CAS alerts is addressed directly with the person assigned and, where appropriate, escalated at the Divisional Performance Review meeting and/or PSQG.

ASSURANCE

For the two alerts subject to inspection by the Care Quality Commission in May 2018, the following assurances can be provided:

(i) **NHS/PSA/D/2016/009 *Reducing the risk of oxygen tubing being connected to air flowmeters***

The alert was issued on 04/10/2016 and closed within deadline on 28/06/2017

Action required	Actions completed	Evidence provided
Identify a named individual who will take responsibility for co-ordinating the delivery of the actions required by this alert.	Acting Head of MEMD identified to coordinate delivery	Email confirmation and regular updates from Acting Head of MEMD
Implement systems to ensure that the three barriers to human error described in this alert are all in place in all relevant clinical areas.	**Barrier 1 -** Medical air terminal units (wall outlets) are covered with caps where there is no need for medical air The Trust does not have any medical air flowmeters in use; therefore barriers 2 & 3 are not required	Email evidence of work order for monitoring of blanking plugs installed received
Establish ongoing systems of audit or equipment checks to ensure the barriers are maintained.	Annual inspection of installed blanking plugs included in routine medical equipment maintenance schedule	Email evidence of work order for monitoring of blanking plugs installed

(ii) **NHS/PSA/RE/2016/006** ***Nasogastric tube misplacement: continuing risk of death and severe harm***

The alert was issued on 22/07/2016 and closed within deadline on 19/04/2017

Action required	**Actions completed**	**Evidence provided**
Identify a named executive director who will take responsibility for the delivery of the actions required in this alert	Medical Director confirmed.	
Using the resources supplied with this alert, undertake a centrally coordinated assessment of whether your organisation has robust systems for supporting staff to deliver safety-critical requirements for initial nasogastric and orogastric tube placement checks.	Self-assessment developed using the resources supplied with the alert; clinical leads identified for both adult and paediatric services. Self-assessments complete.	• April 2017 Board Minutes. Public Board Report – 13/04/2017 including self-assessment and action plan.
If the assessment identifies any concerns, use the resources supplied with this alert to develop and implement an action plan to ensure all safety-critical requirements are met.	Action plan developed and updated with further actions added which is being monitored by the Nutritional and Hydration Group	• Action plan • Updated Nasogastric Care Policy Adult Settings • Nutrition Nurse in place. • Competency and training pack plus list of staff trained

Actions that relate to training have commenced but will remain ongoing actions. We are therefore recommending to Board that these alerts remain closed on the CAS system.

ASSURANCE RISK

On a broader point, in 2017, with the support of the Board Risk Committee and in response to a cohort of serious incidents relating to delays reporting or acting on reports of abnormal radiological imaging, the Director of Governance and Quality Improvement commissioned the Trust's internal auditors to carry out a detailed review of *NPSA Patient Safety Alert 16: Early identification of failure to act on Radiological imaging reports*[1]. The outcome of the audit in 2017 was limited assurance. Of the 15 requirements in the 2007 Alert[1], seven had been fully completed, five had been partially completed and three had not been completed at the time of audit in 2017. This finding was not unexpected given the number and nature of serious incidents identified in 2017. Action was taken as identified and required by Internal Audit. The Audit Committee has considered the assurance and is monitoring implementation of the recommendations. The Trust's review of a historic alert following a run of serious incidents represents a bold, courageous and progressive step towards exemplary governance practices. In doing so, this has highlighted implementation challenges; but it also helpfully illustrates the assurance risk for boards.

[1]This alert was issued in February 2007. It is extremely difficult to locate online which may also represent a risk in itself. The alert can be located using the following link. http://webarchive.nationalarchives.gov.uk/20171030124207/http://www.nrls.npsa.nhs.uk/resources/?entryid45=59817&p=14

PROPOSED PERIODIC TESTING

We propose periodic independent testing to be carried out by Internal Audit, of a sample of current and historic alerts, using a purposeful sampling strategy to isolate those alerts which may pose a risk to board assurance. Such alerts would typically include those:

- where the alert requires that an action plan be developed, but does not specifically state the action plan must be implemented (a minority of alerts specify a requirement for an action plan to be implemented in order to close the alert on the Central Alert Broadcast System);
- that span more than one division, where there one might reasonably anticipate difficulties associated with ownership and control; and
- alerts that concern the application of clinical practice (how practitioners should act) that are 5 or more years since issue.

ACTION REQUIRED

The Board are invited to:

1. note the letter from NHSI (Appendix 1);
2. note the assurance provided in respect of the index alerts;
3. note the risk to assurance for alerts issued prior to 2017;
4. consider and approve the proposal to undertake independent testing of alert implementation going forward.

Jacqueline Robinson, Risk & Assurance Manager
18/06/2018