Bradford Teaching Hospitals
NHS Foundation Trust

Quality Oversight and Assurance Exception Profile: November 2020

Together, putting patients first

Quality Oversight System

The Quality Oversight System has operated in a format modified in response to COVID. Learning has been generated through QuOC, IPMG and through the Command and Control infrastructure (in relation to COVID specific issues). The formal Learning Hub is currently suspended.

Quality key performance indicators

The Trust Quality, Performance and People Dashboards are used contemporaneously throughout the Quality Oversight System to triangulate with other sources of information and to enable surveillance and identification of potential latent and actual risks to quality. All data collection for the 'classic' Safety Thermometer and the 'next generation' Safety Thermometers stopped after March 2020. The PMSU will in future support the delivery of national patient safety collaboratives.

Risk

Review of all COVID related risks completed in November, with a Dashboard indicating all mitigation in place and actions already taken, being presented at Executive Management Team and the Extraordinary Board Meeting 3rd December 2020. Care Groups to review and update any open local risks.

Incidents

The Trust's Incident Management process is used to ensure a proportionate and timely response to incidents reported in the Trust. Pilot in Urgent and Emergency Care -email and telephone notification 09.12.2020 along with safety culture survey.

Active Quality Surveillance

Maternity service remains under executive review.

Our Regulators

CQC The Trust responds to requirements and requests of our regulators through the Quality Oversight System.
There were:
12 CAS Alerts received in November, only one alert required a response, however we identified and have taken internal action on 6 of these.
4 RIDDOR reportable incidents
1 SHOT reportable incident
CQC requested an update on recent Serious Incidents completed and sent 07/12/2020

Assurance

Review of Serious Incidents actions between 2014 and 2017 completed and circulated through IPMG. Review of Serious Incidents completed from 2018 onwards to commence. Status report to go to Patient Safety Sub-Committee in January 2021.

Inquests

Inquest held on 11.11.20. - cardiac arrest/death of patient undergoing acute surgery for washout and debridement of right groin/thigh abscess. Further information requested and Inquest adjourned.

Claims

T/MH/KHAM/I Conference with counsel – missed opportunity to identify meningioma on scan. Decision - to defend.

Heat Map/Quality & Safety Tool

The Heat Map highlights harm from specific incidents – falls/pressure ulcers/infection control and also demonstrates staffing issues/absences. Together with the Quality & Safety Tool it has identified a theme of incidents occurring as a result of staffing.

Quality Summit

None.

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Patient Experience

Complaints have increased during this period. Relative visiting has been reviewed again recently in view of the second wave of the COVID Pandemic.

Mortality

HSMR – 101.07 (Rebasing Period YTD) (October 2019 - September 2020) Represents that the trust is below or between the 95% Control limits.
SHMI – 100.71 (September 2019 - August 2020) The trust is below or between the 90% Control limits.

Effectiveness

Following an alert from the NPCA a review of 90 day re-admissions for men undergoing radical prostatectomy between 1 April 2018 and 31 March 2019 was undertaken. There were 54 patients identified as re-admissions . The review sought to understand the causes of re-admissions and identify learning and areas for improvement.

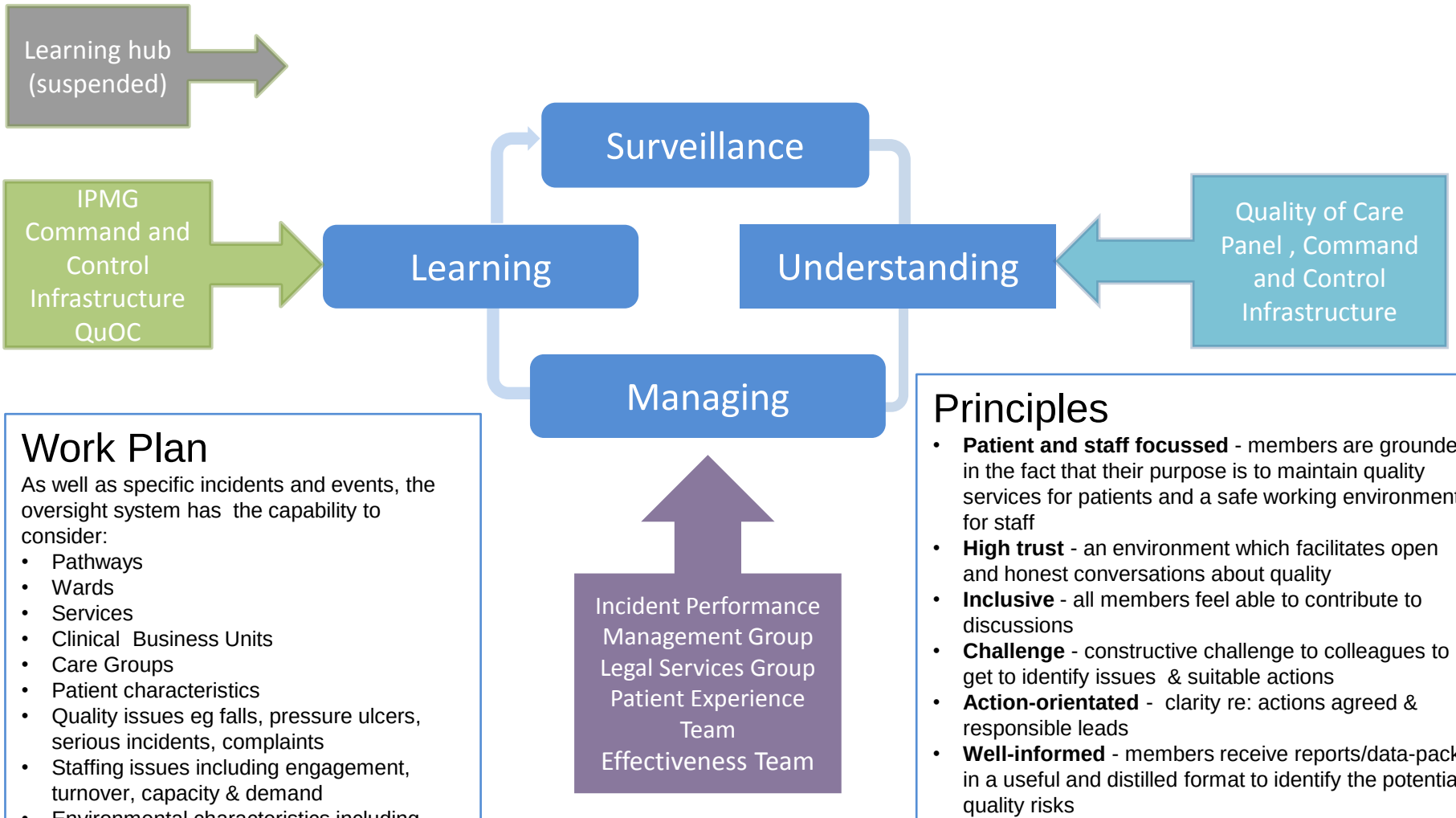
Learning

A thirteen year old boy was being treated for a respiratory illness. He suffered a sudden cardiorespiratory arrest and sadly died. Following an internal and external review a number of key recommendations were made including improving Consultant oversight, clinical care, teaching, ward organisation and the investigation process.
Actions taken as a result of system shared learning re NIV equipment.

Quality Improvement

The Patient Deterioration Tile has been rolled out across wards and to staff in order to improve the recognition, response and escalation of the deteriorating patient.

Quality Oversight System



Work Plan

As well as specific incidents and events, the oversight system has the capability to consider:

- Pathways
- Wards
- Services
- Clinical Business Units
- Care Groups
- Patient characteristics
- Quality issues eg falls, pressure ulcers, serious incidents, complaints
- Staffing issues including engagement, turnover, capacity & demand
- Environmental characteristics including IPCC

Principles

- **Patient and staff focussed** - members are grounded in the fact that their purpose is to maintain quality services for patients and a safe working environment for staff
- **High trust** - an environment which facilitates open and honest conversations about quality
- **Inclusive** - all members feel able to contribute to discussions
- **Challenge** - constructive challenge to colleagues to get to identify issues & suitable actions
- **Action-orientated** - clarity re: actions agreed & responsible leads
- **Well-informed** - members receive reports/data-packs in a useful and distilled format to identify the potential quality risks
- **Comprehensive** - system has a planned and defined business cycle which enables them to consider potential risks in all areas within their remit, across both Care Groups & Corporate Departments

Externally Reported Incidents November 2020

Incident date	Datix number	Incident details	Action and Learning
RIDDOR reportable incidents			
02/10/2020	WR103690 Ref: 13B1161331	**Injury preventing work or usual work tasks for more than 7 days.** Two members of staff were moving boxes through an office environment. It is indicated that during the task, one of the members of staff sustained a back injury.	**Action** Staff were advised on the correct process for moving equipment: 1. Have the items transferred by porting services rather than moving these themselves. 2. In the event that portering service are unavailable, staff should use moving handling equipment (trolley/cage) to transfer the items. 3. In the event that moving handling equipment (trolley/cage) is unavailable, staff should leave the items until portering services are available transfer them. **Learning** Staff should not move large items without the correct equipment.
11/09/2020	WR101956 Ref: E717017AFA	**Injury preventing work or usual work tasks for more than 7 days** Whilst assisting with the rolling of a bariatric patient to support their personal care, a member of staff sustained an injury to their shoulder.	**Action** 1. The Moving and Handling team were consulted and attended the ward to assist staff with moving the patient safely. 2. Moving and handling assessment was undertaken which indicated the number of staff required to move patient. 3. The bed was replaced according to patient need. **Learning** The Moving and Handling team should be involved earlier when bariatric patients are admitted to the ward, to assist with developing affective manual handling plans and advice on the suitability of equipment.
28/08/2020	WR101222 Ref: 169EFACFDB	**Injury to member of public resulting in being taken to hospital** A patient sustained fractured Neck of Femur during a fall which required surgery. Initial RCA highlighted that not all preventative measures were in place.	**Action** Actions identified following RCA 1. Staff to review/complete falls assessment on transfer and daily and put appropriate measures to mitigate risk 2. Use of falls alarm for high risk patients. 3. Escalate risk if unavailable at handover and safety huddles. 4. Staff to complete triple screen assessment on transfer of patients with cognitive impairment, referring to specialist Dementia Nurse if required. **Learning** Falls assessments to be completed on admission / transfer and reviewed daily. Documentation to reflect mitigation actions in place and escalation when equipment is not available.
17/10/2020	WR103042 Ref: 13B1161331	**Injury preventing work or usual work tasks for more than 7 days** A member of the public gained access to a clinical area. He subsequently brandished a weapon and threatened staff. As a result of this incident, the porter threatened by the member of the public has been off work	**Action** A serious incident investigation is currently underway completion date 15.01.2020.
SHOT reportable incidents			
05/11/2020	WR103732 Ref: 2020/011/021/HV1/004	**Incorrect unit collected from issue fridge and brought to clinical area (near miss)** A patient attended the day unit for a routine blood transfusion. Whilst there, a member of staff retrieved Incorrect blood for the patient's blood transfusion. The error was detected upon the receipt of the blood and the blood was not transfused.	**Action** The staff member to re-attend the Mandatory Transfusion Training and recomplete the Transfusion Competency Assessments. **Learning** The root cause analysis will be shared with the relevant areas Clinical Governance for cascading amongst the team.

Incidents

Daily risk huddle

The Trust wide daily risk huddle occurred on every working day with a total of 88 incidents being discussed during this period and escalated appropriately.

Top 5 Reported Incidents

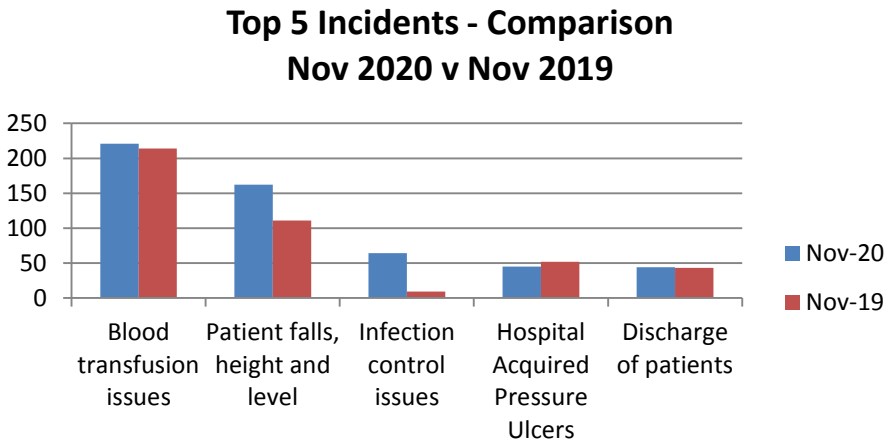
Through daily horizon scanning and interrogation of Datix, the Top 5 reported incidents are monitored and analysed for consideration within the Quality Oversight System through the Incident Performance and Management Group and additional assurance sought as required. The graph above shows a comparison of the Top 5 incidents in November 2020 to November 2019. Further work is being carried out to understand the increase in incidents as well as interrogate the data in relation to the IPC Incidents and Covid.

COVID specific incidents

Incidents relating to COVID are routinely reviewed at the daily risk huddle and in the context of the silver conference call. Weekly COVID huddles recommenced in November. There has been an increase in the number of incidents reported during this period.

Themes and Trends

The Quality Oversight System continues to review all incidents and triangulate the contributory factors with other sources of intelligence. The current themes are staffing issues, violence and aggression against staff and delays in treatment, all related to the COVID pandemic, there is also a theme of ambulance transfer delays which is being resolved. Further work is being undertaken to explore different methods of analysing and presenting data to understand trends overtime.



Incidents (continued)

Moderate and above harm incidents

Review and consideration of immediate actions in relation to contributory factors associated with moderate and above harm incidents. 4 Serious Incidents were declared in November. See SI paper for full detail.

SI 2020/20817: Slips/trips/falls meeting SI criteria
(Also RIDDOR)
A patient sustained a fractured neck of femur (NOF) during a fall which required surgery. The initial root cause analysis (RCA) highlighted that not all the preventative measures were in place that should have been to avoid this fall occurring.

Immediate learning:
- Review of risk assessment or completion of an individual risk assessment was not been undertaken on transfer from other areas of trust therefore not identifying risks and mitigation measures to be put in place to maintain patient safety.

SI 2020/21772: Surgical/invasive procedure incident meeting SI criteria
A 19 year old patient underwent facial reconstruction surgery. There were possible omissions in the decisions made regarding timing of surgery and availability of the necessary equipment required to undertake the surgery safely.

Immediate learning:
- The Foundation Trust decontamination policies and procedures were not followed for required equipment.
- Patient was listed without an appropriate timescale to take into account decontamination of equipment in line with the Foundation Trust policies.

SI 2020/21921: Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant)
A 34 year old pregnant woman presented at 38 weeks gestation with an intrauterine death.

Immediate learning:
- No process of informing the lead community midwife of woman who DNA their GTT appointment. (Process now in place)
- Specific guidance on what action to take for women of advanced gestations was required from the diabetic consultant.

SI 2020/27904: Pressure Ulcer meeting SI criteria
Patient developed deep pressure ulcers (category 3/ un-gradable) to both inner thighs secondary to repeated use of incorrectly sized sling.

Immediate learning:
- The Moving and Handling team should be involved earlier when bariatric patients are admitted to the ward, to assist with developing affective manual handling plans and advice on the suitability of equipment.

Effectiveness & Learning

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Learning from Serious Investigations -Unexpected Death of a Child

A thirteen year old boy was being treated for a respiratory illness. He suffered a sudden cardiorespiratory arrest and sadly died. Following an internal and external review a number of key recommendations were made including improving Consultant oversight, clinical care, teaching, ward organisation and the investigation process.

Issues	Recommendations – actions and completed actions ✓
1. Consultant Overview	✓ Consultant review for all children on aminophylline. ✓ Appointment of 2 Consultant paediatricians to have lead for ward acute care ✓ Formation of MDT for children not following typical course • Develop framework to ensure lead Consultant identified early for complex cases (Nov 2020) • Complete modelling for twilight Consultant shift (Dec 2020)
2. Clinical Care	✓ New guideline to be introduced for acute asthma ✓ SOP in place to ensure lead Consultant identified. MDT routinely checking this has occurred for complex cases ✓SOP rewritten to ensure that humidified oxygen used early in presentation.
3. Teaching	• Simulation sessions to occur for Consultants, trainees and nurses to standardise care of acute asthma, need for escalation of care and ability to escalate concerns and question treatment pathways (Jan 2021) ✓ Case discussed with Consultant and trainees previously. Needs further discussion in light of external review ✓ Case included in induction training for each group of trainees
4. Ward organisation	✓ Twice daily huddles between nursing coordinator and consultant to ensure all staff members have clear route to escalate concerns
5. Investigations	✓ Any unexpected deaths on the ward to be routinely reviewed at the stabilisation meeting with EMBRACE. • Update learning methods in line with new guidance for the Patient Safety Committee (Dec 2020) • Develop guidance for escalation of care for complex cases to tertiary centre & framework of guidance to ensure external review is routinely carried out in cases where unexpected deaths or significant events occur (Jan 2021).

National Audit Programme: National Prostate Cancer Audit (NPCA)

Following an alert from the NPCA a review of 90 day re-admissions for men undergoing radical prostatectomy between 1 April 2018 and 31 March 2019 was undertaken. There were 54 patients identified as re-admissions . The review sought to understand the causes of re-admissions and identify learning and areas for improvement.

The review revealed that only six patients required an overnight stay. The two main reasons included waiting a senior review or imaging to confirm absence of any serious complications. There were 12 patients who re-attended with a urinary tract infection (UTI) or possible UTI.

Key leaning points from the review process:

- Review the process of data submitted to the audit to ensure accurate reflection of re-admission as defined by the NPCA
- Ensure pre-operative MSUs are performed routinely
- Peri-operative antibiotic prophylaxis modified following discussion with the microbiologist
- Reducing variation in practice with all three surgeons routinely using the same type of suturing to decrease the risk of to pelvic haematomas post prostatectomy
- Encourage patients to seek advice and attend reviews with the urology team

Quality Improvement

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QI Trust Priority: Preventing Deterioration and Sepsis

The Patient Deterioration Tile has been rolled out across wards and to staff in order to improve the recognition, response and escalation of the deteriorating patient. Using improvement approach we have run a Plan-Do-Study-Act cycle during November. Data demonstrates that the tile has been received positively by staff, average completion rates for NEWS2 scores have been 94% and the number of patients with delays to having Observations taken and recorded reduced.

Prediction and Plan

We think that the PD Tile will increase NEWS2 scores completion rates on EPR and reduce the number of overdue observations for patients with NEWS2 score of 1 or more.

- Task force team created
- Staggered roll out across 16 wards
- Training delivered to individual wards resources
- Virtual training for Junior Doctors
- Bespoke Patient Deterioration education to wards 1, 4 and 17
- Daily visits by task team
- Focussed test of change on ward 26 and 27 with HCA's to improve completion of EWS

Do

- Ward visits and training delivered
- Daily sense check and feedback to GE
- Identifying issues with IT
- 2 training sessions delivered virtually to Junior Doctors

Study

- Data demonstrates improvements with NWES2 scores being completed and reduction in number of over due observations. This means we are improving the monitoring of our sickest patients.

- Wards require regular visits to embed training how to use the Tile
- Quick response to explore issues with the tile with GE and IT
- Junior doctors using the tile to prioritise work out –of-hours
- Good engagement on the wards including non-clinical support staff
- Nursing staff using the Tile to prioritise workloads

Act

- Adopt and Adapt – continued engagement, support and training for wards and key staff groups
- Plan for ensuring improvements are spread and sustained across the organisation

NEWS2 Completion Rates