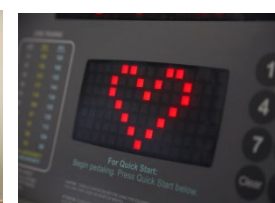
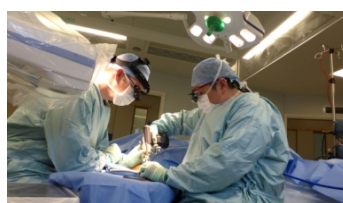


Quality Oversight and Assurance Exception Profile Quality Academy: April



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 Exec Team and Business Intelligence are to review and develop quality metrics associated with all dashboards.

Risk

The Risk Management Strategy is currently under review. Risks have been aligned to the appropriate Academies.

Incidents

The Trust's [Incident Management process](#) is used to ensure a proportionate and timely response to incidents reported in the Trust. There were 3 Serious Incidents declared between 15th March and 16th April 2021. Trust has linked in with the Improvement Academy in a number of areas including; trache care and support of staff with mental health issues. Links being made with Leeds Acute Trust to look at their de-escalate programme for violence and aggression.

Active Quality Surveillance

There are currently no services under surveillance.

Quality Summit

There are currently no ongoing quality summits.

[Patient Experience](#)

There were 36 complaints, 152 PALS issues and 61 compliments received in March. 54 complaints and 152 PALS issues were responded to.

Our Regulators

The Trust responds to [requirements and requests](#) of our regulators through the Quality Oversight System. There were:

8 CAS Alerts received in March, 7 of which required no response through the CAS process. We identified and have taken internal action on all of these alerts. NatPSA/2021/001/MHRA – Supply disruption of BD sets. Response through CAS process completed.

Weekly meetings to monitor evolving situation with stock shortage. Vulnerable groups identified to provide bespoke solutions. Working closely with NHSE to secure alternative alongside Trust embarking on changing current volumetric pumps to alternative with support and compliance training programme.

1 RIDDOR reportable, 1 IR(ME)R and 2 SHOT reportable incidents.

CQC monthly engagement meetings held where updates on Serious Incidents is shared. CQC request for updates on certain incidents in progress. HSE are restarting inspections of COVID related issues. Trust COVID related staff death formally closed with no further action for the Trust.

Inquests

Remote hearings for Inquests continue. 2 Inquests heard in March. One related to Orthopaedics/Vascular/General/Plastic Surgery and the Trust received a REGULATION 28 in respect of concerns around communication between consultants and specialties. One related to Urology and subsequent complications which were not linked to surgery. 2 inquests listed for later March have been cancelled and three are listed for April/May and June.

Claims

In March the Trust formally responded to 4 Clinical Claims making admissions, 3 of which were an acceptance of liability and 1 of which was on the basis of Litigation Risk.

Alert

Advise

Assure

Assurance

The update on assurance against action plans arising out of Serious Incidents presented to the Quality Academy in March was subsequently was presented at the Patient Safety Sub Committee on 14.04.2021.

Learning

The Spring Edition of the [BTHFT Mental Health Bitesize Newsletter](#) is available for information. HSIB report received on Maternal Death (WR101340) – The Maternity Risk Team have produced an SBAR to identify learning points.

Clinical Outcomes

High Priority Audit Programme – to be presented at the Quality Academy in April for sign off. Planning and re-design of processes to support the management of national and local audits in progress.

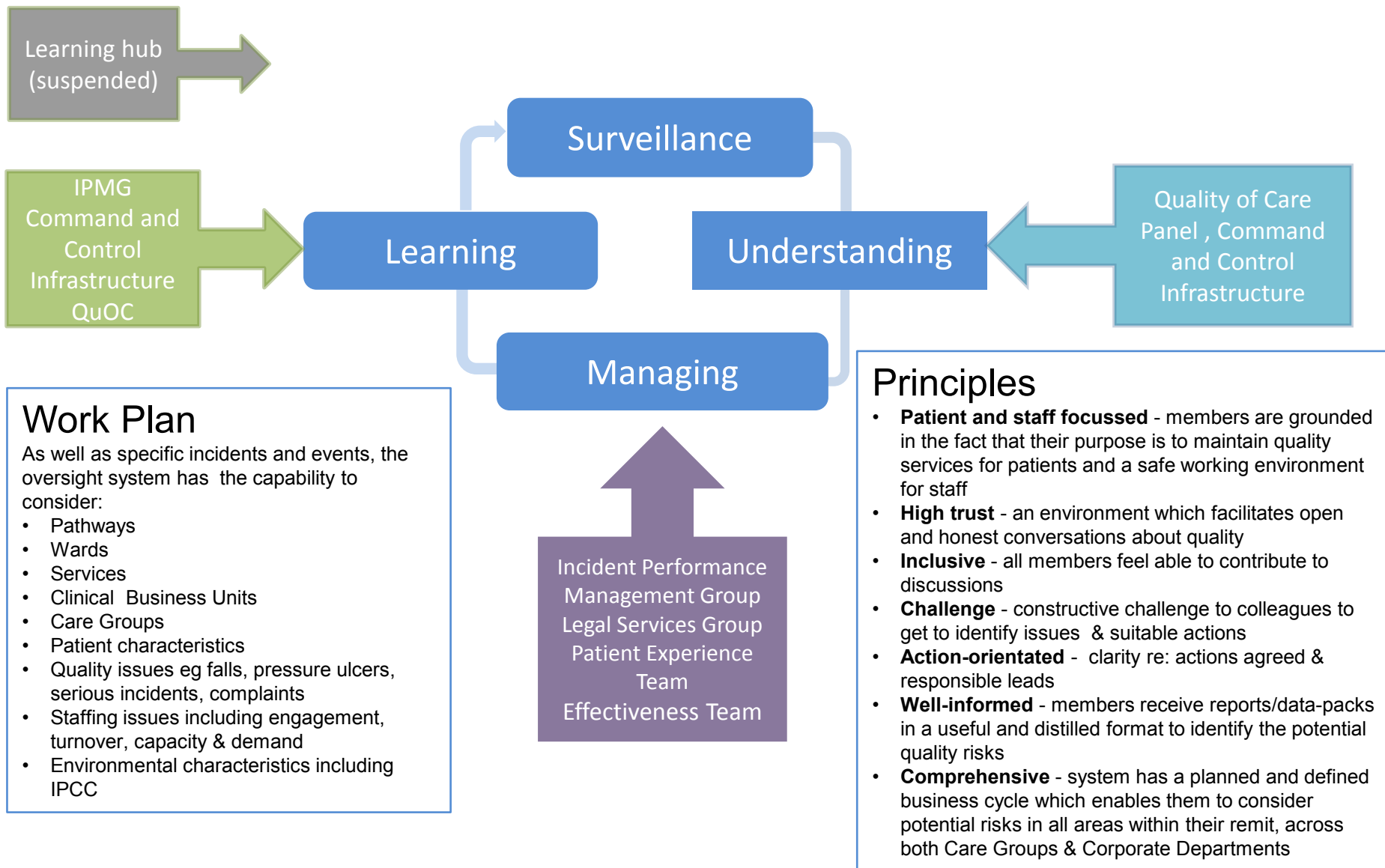
[Mortality](#)

FOI 20533 submitted – SJRs completed since January 2020 and how many related to COVID. SHMI score: 103.86 (January 2020 to December 2020) HSMR score: 99.96 (Rebasing period YTD February 2020 to January 2021) Ongoing discussion held with BI to understand and explore SHMI data.

Quality Improvement

HSIB Report – Neonatal Death (WR101965). Report and Maternity Response. Work being commenced by the Quality team to understand and improve the Duty of Candour process.

Quality Oversight System



Incidents

Daily risk huddle

The Trust wide daily risk huddle occurred on every working day with a total of 62 incidents being discussed during this period and escalated appropriately through Incident Performance and Management Group.

Themes and Trends

The Quality Oversight System continues to review all incidents and triangulate the contributory factors with other sources of intelligence. There was a theme relating to patient placement identified in March and this is being monitored and explored through the 'We Are Listening' test of change. Work continues around the exploration of different methods of analysing and presenting data to understand trends over time. The Quality Team are developing a systematic approach to understand and use qualitative data from Datix to help inform assurance, learning and improvement activities.

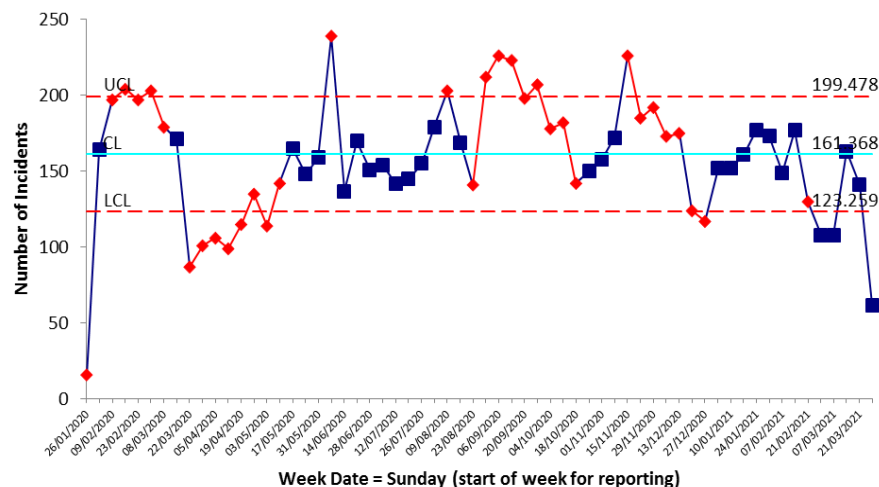
COVID specific incidents

Incidents relating to COVID are routinely reviewed at the daily risk huddle and in the context of the silver conference call. Weekly COVID huddles are ongoing. There has been a decrease in the number of incidents related to COVID, which is expected.

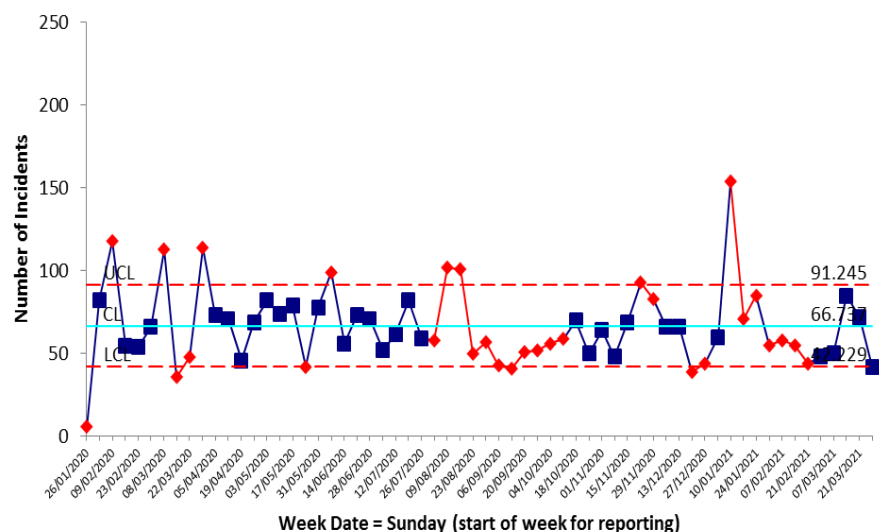
Low and no harm incidents

The Quality Governance and Quality Improvement Teams continue to look at various ways to extract free learning from low and no harm claims and these are monitored through QuOC.

No Harm Incidents



Low Harm Incidents



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. 1 Serious Incidents were declared in March. See SI paper for full detail.

SI 2021/8095: HCAI/Infection control incident meeting SI criteria

A formal cluster of Hospital Onset Covid Infection Deaths (14) as defined by NHSE, have been reported by the Infection Prevention and Control Team, in accordance with Trust incident management procedures.

Immediate Learning

- The initial review of these cases has identified the difficulties in identifying asymptomatic patients.
- Multiple transfers of patients in a dynamic and evolving situation to accommodate admissions.
- The importance of documenting the patient's current swabbing status so any omissions can be identified and early identification of a changing COVID-19 status.

SI 2021/8107: HCAI/Infection control incident meeting SI criteria

A formal cluster of Hospital Onset Covid Infections (17) as defined by NHSE, have been identified and reported by the Infection Prevention and Control Team, in accordance with Trust incident management procedures.

Immediate learning:

- The initial review of these cases has identified the difficulties in identifying asymptomatic patients.
- Multiple transfers of patients in a dynamic and evolving situation to accommodate admissions.
- The importance of documenting the patient's current swabbing status so any omissions can be identified and early identification of a changing COVID-19 status.

SI 2021/6621: Adverse media coverage or public concern about the organisation or the wider NHS

On Sunday 21 March 2021 a member of our agency Domestic staff was arrested outside the Trust following some serious allegations. The Trust is working with the police as part of their on-going investigation.

Immediate learning:

- There has been no identified learning following the initial investigation.

Patient Experience

- In March the Trust received a total of 36 complaints and 61 compliments; therefore more compliments were received than formal complaints for this month. The Trust also received a total of 152 PALs issues.
- The top themes in complaints were; care and treatment issues and attitude and behaviour.
- The top theme in PALs were; appointments and care and treatment issues.
- There are a total of 66 open complaints currently for the Trust with 7 of these ready to be signed off.
- There are no complaints that are over 6 months.

Patient Experience (continued)

March 2021: Patient Experience Contacts		March 2021: Patient Experience Closed	
Complaints received:	36	Complaints responded to:	54
PALs issues received:	142	PALs issues responded to:	152
March 2021: Complaint Received			
Themes by Subject		Top 5 Themes by Sub-subject	
	Total		Total
Appointment	2	Inappropriate discharge	6
Attitude & behaviour	12	Appropriateness of treatment	6
Care and treatment issues	14	Unprofessional	6
Communication	9	Patient and/or relatives not being informed	5
Delay in diagnosis	6	Care issues for vulnerable patients	4
Discharge	6		
Discrimination	1		
Fall, slip or trip on same level	1		
Food quality issues	1		
Information security breach	1		
Medication	3		
Patient procedure issues	4		
Theft, loss or damage of personal property	1		
Transfer	1		
Total	62		

Patient Experience (continued)

March 2021: PALS Received			
Themes by Subject		Top 10 Themes by Sub-subject	
	Total		Total
Appointment	36	Unprofessional	14
Attitude & behaviour	18	Appropriateness of treatment	14
Care and treatment issues	23	Patient and/or relative having difficulty making contact with organisation	10
Communication	31	Delayed results	9
Delay in diagnosis	13	Appointment - Failure to arrange follow up	8
Discharge	11	Patient information	7
Environment issues	6	Patient and/or relatives not being informed	7
Equipment issues	2	Loss of property	6
Infection control	1	Inappropriate discharge	6
Information security breach	1	No contact from clinician for an arranged telephone appointment	5
Medication	5		
Medical records issues	2		
Patient procedure issues	5		
Theft, loss or damage of personal property	7		
Transfer	2		
Transportation issues	1		
Visiting issues	3		
Total	167		

Do we respond effectively to safety issues?

Risk assessment and response to NPSA (BD giving sets)

National Patient Safety Alert (NPSA)

- A NPSA alert was received 11th March 2021 reference NatPSA/2021/001/MHRA
- The alert related to the supply disruption of sterile infusion sets and connectors manufactured by Becton Dickinson (BD) .
- BD have notified MHRA that the sterility of some of their devices cannot be guaranteed due to quality issues with their third-party sterilisation provider.
- BD were recalling the affected devices :
 - Infusion sets for specific Alaris pumps
 - Gravity infusion sets and connectors
- Although the devices are likely to be sterile this cannot be guaranteed so there is a very small risk of infection from treatment with these devices. There will be supply disruption whilst BD transfer products to a new sterilisation provider.
- The quality issue was recently identified but has been ongoing for a number of years. No infection issues have been identified relating to these products.
- The risks of rapidly changing clinical practice or using unfamiliar devices must be balanced against the risk of continuing to use these products while they remain available.

Do we respond effectively to safety issues?

Risk assessment and response to NPSA (BD giving sets)

Risk Assessment

A Risk assessment was produced that identified the following hazards:

- Continue to use the affected BD products in light of the Safety alert
- Lack of Availability of affected BD infusion sets and gravity infusion sets and connectors
- Transferring to an alternative product that is not a like for like alternative
- Lack of trained staff, for alternative products.
- Impact on the Training Department if face-to-face training is utilised to train staff
- Inconsistent infusion rates due to not using a syringe pump/infusion set.
- Unnecessary blood donor exposure. Should a gravity infusion reach maximum time allowed out of the blood fridge due to going undetected as running slow further blood unit/s may be required.
- Litigation risk.
- Reputational risk.

The risk rating was moderate:

Rationale although BD are recalling their products now, the information in the alert states that this has been an ongoing issue for some years, which does not appear to have caused harm to patients, due to a lack of evidence of infections associated with the use of the affected products being highlighted. The Trust has some alternative volumetric pumps that they can start to roll out. Alternative products are being considered.

Do we respond effectively to safety issues?

Risk assessment and response to NPSA (BD giving sets)

BD stock Plan and current position

- Preservation of current stock and formation of a central hub for distribution of stock
- NHS supply chain are centrally managing stock
- Alternatives sourced where available and training provided
- Infection and Prevention included in discussions and decision making process
- Reconfiguration of pump to semi designated (enabling pump to be utilised without pressure sensor giving set) to be considered by Clinicians.

New Volumetric pump roll out brought forward - Fresenius

Multi- disciplinary Team (MDT) Working group

Roll out plan devised

Training delivery agreed with Fresenius , key trainers identified

Training commenced on 29th March for 5 downstream wards 18, 20, 21, 26 and 28

Once 70% of staff are trained on the ward , existing Alaris pump will be removed and replaced with Fresenius.

Training will be added to staff mandatory training on ESR

Currently 82 Fresenius pumps in Organisation

Another 120 to arrive w/c 5th April

Further 300 on order

Consumables identified and available for order when required

Configurations agreed for Adult areas, work ongoing by pharmacy to finalise further 3 remaining configurations for paediatric, neonatal and ' Critical Care' adults (ICU, AED Resus, Theatres, CCU)

Global communication has been circulated for all staff regarding both of the above

Externally Reported Incidents March 2021

Incident date	Datix number	Incident details	Action and Learning
RIDDOR reportable incidents			
04/03/2021	WR107572 Ref: FD11784120	<p>Injury preventing work or usual work tasks for more than 7 days.</p> <p>A member of staff went to the main medical records library (which has restricted access due to the condition of the roof and the presence of asbestos in the ceiling void) to file and pull notes. Whilst in the location the member of staff slipped and fell on wet floor in area where roof had leaked.</p> <p>The member of staff initially had no time off as a result of this incident, but has subsequently been absent from work for more than 7 days as a result of their injuries.</p>	<p>Action</p> <ol style="list-style-type: none"> Estates are liaising with relevant managers within Estates and Facilities and Medical Records to ensure that standard operating procedures (SOP) in place are reviewed and communicated to staff. Recommended that staff should enter the building in twos as a precautionary measure. This incident and the condition of the roof was raised at the Health Safety and Resilience Committee (16 March 2021) by staff side representatives. It should be noted that this issue had only been raised with staff side on the morning of the committee. <p>Learning</p> <ul style="list-style-type: none"> Where access is restricted to a location due to the condition of the building, suitable procedures should be in place for maintenance and access.
IR (ME) R reportable incident			
13/03/2021	WR107925 External Agency's Ref: IRMER38848008	<p>Overexposure of breast screening patient on newly installed Giotto mammography equipment.</p> <p>Radiographer did not notice high exposure and repeated the image due to blurring.</p> <p>Kv 35 mAs 394 ESD 44.42 1st Image</p> <p>Kv 34 mAs 134 ESD 12.56 Repeat Image</p> <p>Image quality/dose noted at time of reporting.</p>	<p>Action</p> <ul style="list-style-type: none"> New protocols been added by manufacturer on the x-ray machine <p>Learning</p> <ul style="list-style-type: none"> Ensure protocols for are newly installed machinery are working.
SHOT reportable incidents			
13.02.21	WR107120 2021/003/004/ HV1/020	<p>Transfusion Reaction</p> <p>68 year old patient admitted with chest pain, with ECG changes and treated as NSTEMI.</p> <p>Whilst receiving a transfusion of red cells, patient complained of feeling unwell, clammy, increased respiratory rate. Known HF. Blood transfusion put on hold. 137ml infused of the 257ml. Dr informed straight away and asked to r/v. Patient deteriorated further, requiring CPR. Treated with Adrenaline, Furosemide and showed improvement with Metaraminol.</p> <p>Cardiologist confirmed the patient suffered an MI during the transfusion. However, Haematologist also advised to investigate for possible TACO.</p>	<p>Action:</p> <p>The transfusion team are currently in the process of completing the RCA.</p> <p>Learning</p>
22.02.21	WR107360 Ref: 2021/003/004/ HV1/021	<p>Procedure performed incorrectly – incorrect administration set used</p> <p>Patient received unit of red cells through incorrect standard giving set which has a 15 micron standard filter.</p> <p>Blood components must be transfused through a blood giving set which has a 170-200 micron filter.</p> <p>The patient was informed of the error and observed. Root cause analysis underway. SHOT reportable as a handling and storage error.</p>	<p>Action:</p> <p>The transfusion team are currently in the process of completing the RCA.</p> <p>Learning</p>



Mental Health BTHFT Bitesize

Spring Newsletter 2021

Issue 1.

HOW MANY OF YOUR PATIENTS HAVE MENTAL HEALTH RELATED ISSUES?

On a daily shift, you may be working with a number of patients who either have mental health difficulties or are developing mental health difficulties. Are you confident of your working practice? Do you feel you need more info? This is a brand new newsletter designed to support staff to ensure best practice for all patients where there are mental health care needs.

Take Note nurse...

Top tips on dealing with agitated patients.

- Offer some time to **explain what is happening** in their care to ease their anxiety
- Support the patient to **call or talk with family/friends** to support their wellbeing
- Have a staff member talk and spend time with the patient to **understand what is causing agitation/distress**
- Reduce stimulation in the area (e.g. quieter bed/side room)
- PRN **medication** prescribed to help calm

Prevalence and Impact of Mental Health

- It is estimated that **1 in 6** people in the last week experienced a mental health problem
- **1 in 5** people experienced a form of depression during the pandemic
- Depression is a **leading cause of disability worldwide** and is a major contributor to the overall global burden of disease
- **Bradford** has a **higher** than national average suicide rate among males (2017-19)

*Data extracted from PHE fingertips and Mental Health Foundation

Signs / Symptoms of anxiety:

- ✓ exaggerated responses / shock
- ✓ Palpitations / chest pain
- ✓ Breathing difficulties
- ✓ Excessive worry / concerns
- ✓ Sweating / temp changes
- ✓ Concentration difficulties
- ✓ Irritability / Sleep difficulties
- ✓ Frequent state of arousal

DID YOU KNOW?

- You can support people to make 'advanced decisions' about their care so their wishes are maintained and respected if they lose capacity
- A person with severe mental health problems' life expectancy can be shortened by as much as 20 years and can result in co-morbidities such as heart disease and diabetes.

Be Mental Health aware...

Mental Health BTHFT Bitesize is a new quarterly newsletter to help share information about mental health to support your practice!

SHMI

RAE | Bradford Teaching Hospitals

6th out of 13 trusts.

(January 2020 - December 2020)

#	Trust	Score
1	RCF AIREDALE	94.37
2	RCB YORK TEACHING HOSPITAL	94.60
3	RCD HARROGATE AND DISTRICT	94.62
4	RHQ SHEFFIELD TEACHING HOSPITALS	100.10
5	RWY CALDERDALE AND HUDDERSFIELD	100.94
6	RAE Bradford Teaching Hospitals	103.87
7	RR8 LEEDS TEACHING HOSPITALS	105.71
8	RFF BARNSELY HOSPITAL	105.87
9	RJL NORTHERN LINCOLNSHIRE AND GOOLE	107.12
10	RXF MID YORKSHIRE HOSPITALS	108.97
11	RP5 DONCASTER AND BASSETLAW HOSPITALS	112.06
12	RFR THE ROTHERHAM	113.72
13	RWA HULL AND EAST YORKSHIRE HOSPITALS	113.99

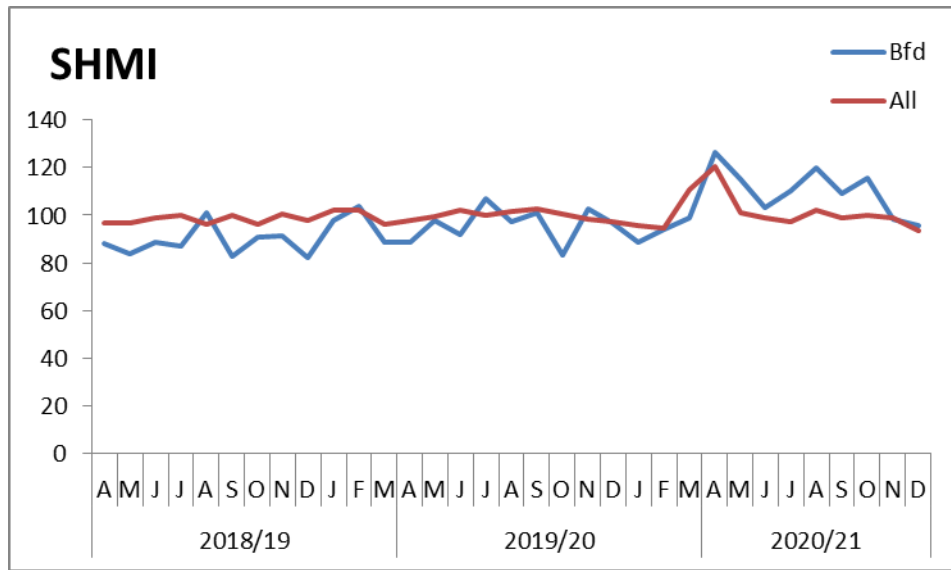
Colouring Key:

Green: Represents that the trust is below or between the 90% Control limits.

Amber: Represents that the trust is between the 90% and 95% Control limits.

Red: Represents that the trust is above the 95% Control limits.

Quality Team - Clinical Outcomes: Understanding our SHMI data – April 2021



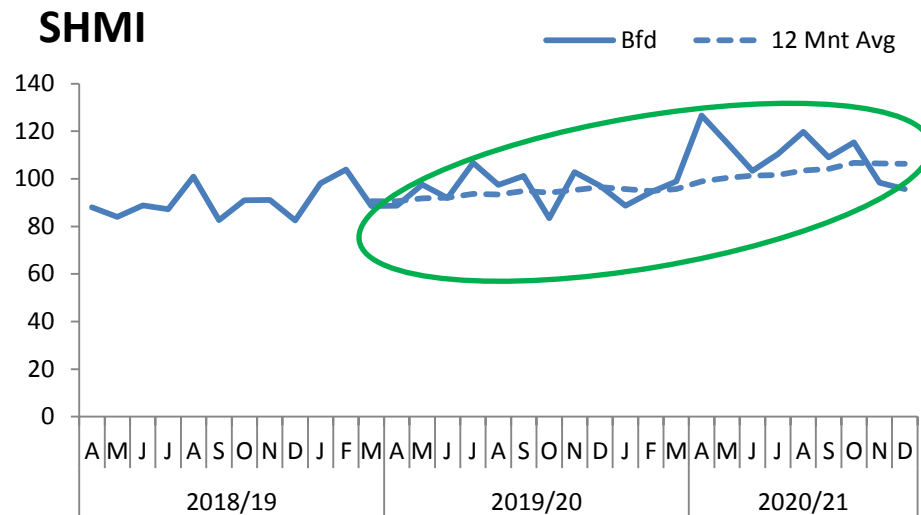
Standardised Hospital Mortality Indicator (SHMI)

SHMI = Number of deaths (in hospital or within 30 days of discharge) / number of expected deaths x 100

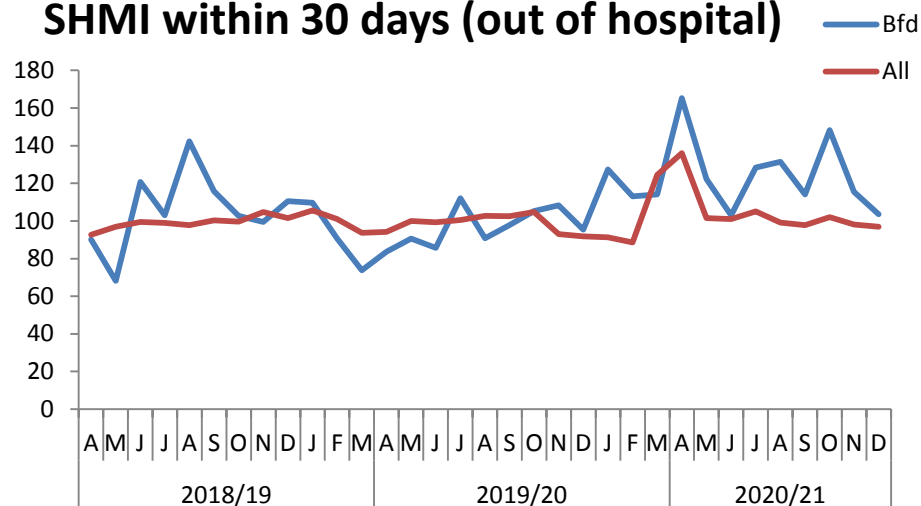
- SHMI reports on mortality at trust level across the NHS in England using a standard and transparent methodology
- As of the July 2020 publication, COVID-19 activity has been excluded from the SHMI
- The SHMI is not a measure of quality of care

Context

- Pre-pandemic SHMI was below or in line with national average- as expected or below expected
- Trend over time since Jan 2019 - SHMI



SHMI within 30 days (out of hospital)



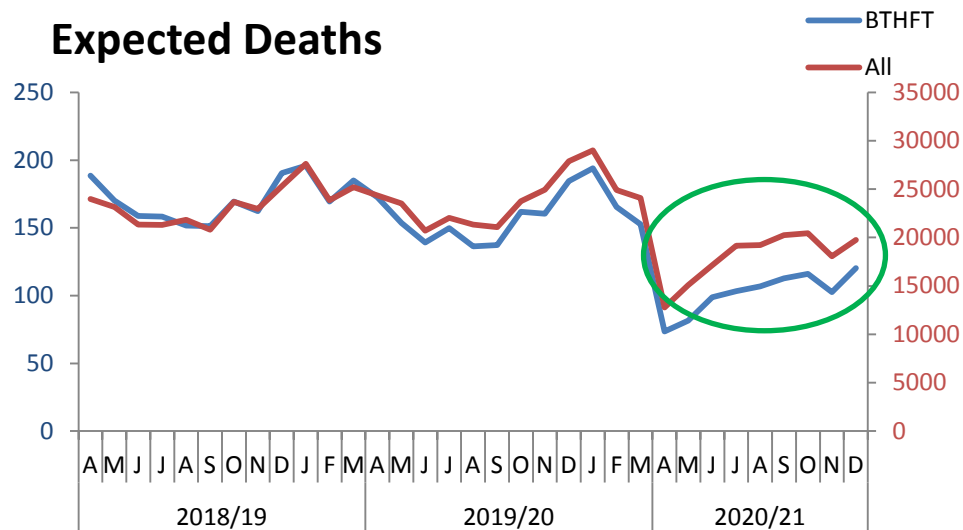
Possible drivers - change in SHMI

- Number of expected deaths post Covid we have seen a bigger reduction

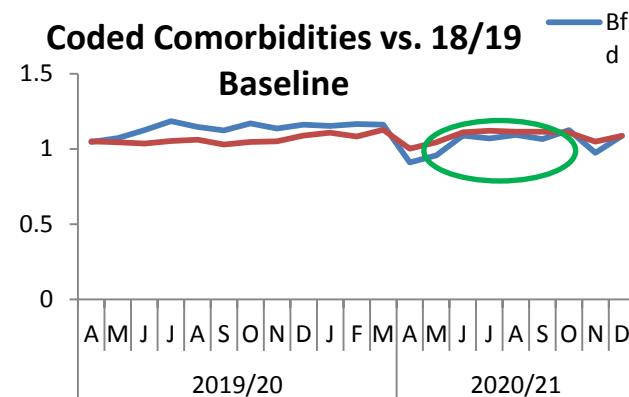
This may be owing to:

- Depth of coding - Case mix
- Specialities skewing data
- Out of hospital deaths affecting overall SHMI

Expected Deaths



Coded Comorbidities vs. 18/19



Actual Deaths

