Bradford Teaching Hospitals
NHS Foundation Trust

Quality Oversight and Assurance Exception Profile
Quality Academy: June 2021

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 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 2 Serious Incidents declared between 17th May and 13th June 2021, one of which was logged by the Trust on behalf of Safeguarding. There are currently 11 ongoing Serious Incidents. Themes are being picked up within Quality Improvement work.

Active Quality Surveillance

There are currently no services under surveillance.

Quality Summit

There are currently no ongoing quality summits.

Patient Experience

There were 32 complaints, 163 PALS issues and 47 compliments received in May. 51 complaints and 183 PALS issues were responded to.

Our Regulators

The Trust responds to requirements and requests of our regulators through the Quality Oversight System. There were:
1 CAS Alert received in May:
NatPSA/2021/002/NHSPS - Vicky Cox/Liz Jones in AED identified to respond by 19.08.2021
2 Alerts outstanding:
NatPSA/2020/006/NHSPS – Inhalation - Non compliant – Risk Assessment completed.
NatPSA/2021/001/MHRA – BD giving sets – work still ongoing.
4 RIDDOR reportable, 1 SHOT and 1 PHE screening reportable incidents.
CQC monthly engagement meeting held on 25th May – presentation by Chief Operating Officer on Covid-19 summary and operational overview. Next meeting 23rd June. Two CQC reports (IRMER) completed and submitted in June, one relating to breast imaging and one relating to CT.

Inquests

Remote hearings for Inquests continue. 1 Inquest heard in May, related to AED – Narrative verdict. 4 inquests listed June/July/August/September. Regulation 28 received – Inquest held in March, related to Orthopaedic/Vascular/Plastics.

Claims

In May the Trust formally responded to six Clinical Claims making admissions. No Claims were settled.

Organisational Learning

WR104557 – SBAR – Neonatal Death (HSIB Investigation) – Maternity compiled report to highlight recommendations and learning.
Quality Team exploring the format for presenting and sharing organisational learning.
Court of Protection Rules – Covid -19 Vaccination
New GMC Guidance – decision making and consent.
Scottish Hospital Trust prosecuted for failure to protect the safety of a patient in their care.

Alert	Advise	Assure

Clinical Outcomes

Terms of reference for the Clinical Effectiveness Committee are currently being reviewed: Name will change to Clinical Outcomes Group and will include arrangements for NICE Guidance and CAS alerts.

Mortality

SHMI score (12 month rolling-March 2020- Feb 2021): 106.39 – Slight increase from previous month but within expected range
SHMI monthly (Feb 2021) 91.69
HSMR score (12 month rolling-April 2020 to March 2021): 100.10 - Slight increase from previous month but within expected range

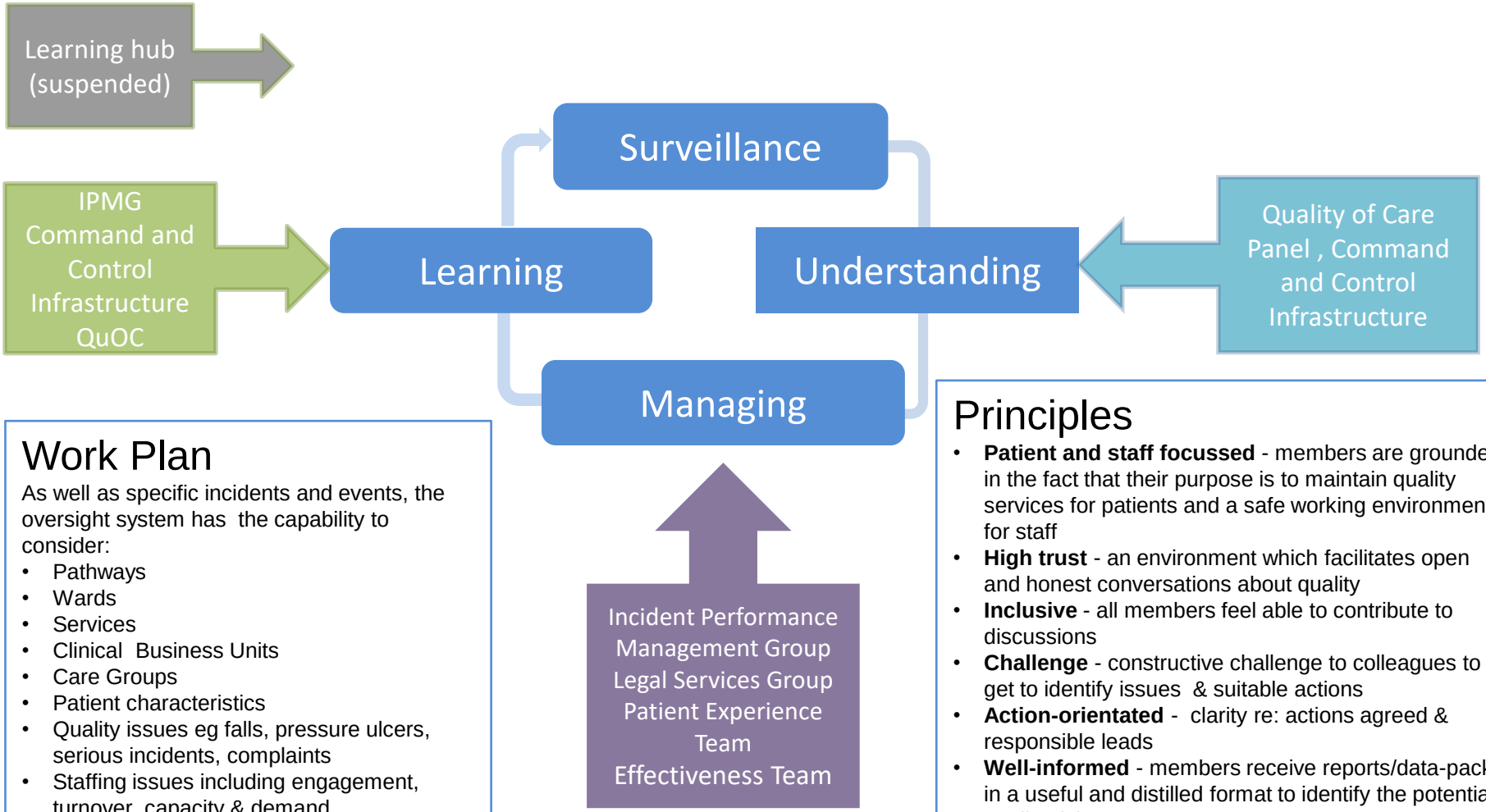
Associate Medical Director appointed and commenced post – June 2021
Improvement Academy hosted master class on Hospital Mortality Statistics
Junior Doctor training on ME office and Learning from Deaths framework

Quality Improvement

QI capacity and capability building;

- QI training delivered (in-house)
- LifeQI – Online platform to manage QI projects , training to be delivered for the Quality Team and users
- Radiology and Imaging CBU – testing model for embedding QI into every day activities
- Trust level Improvement priority: Deteriorating Patient and Sepsis – developing project charter, identifying improvement measures
- Submission to HSJ awards
- Work to improve reported no and low harm incidents within the Transfusion service

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

Incidents

Daily risk huddle

The Trust wide daily risk huddle occurred on every working day with a total of 73 incidents being discussed during this period and escalated appropriately through Incident Performance and Management Group.

Themes and Trends

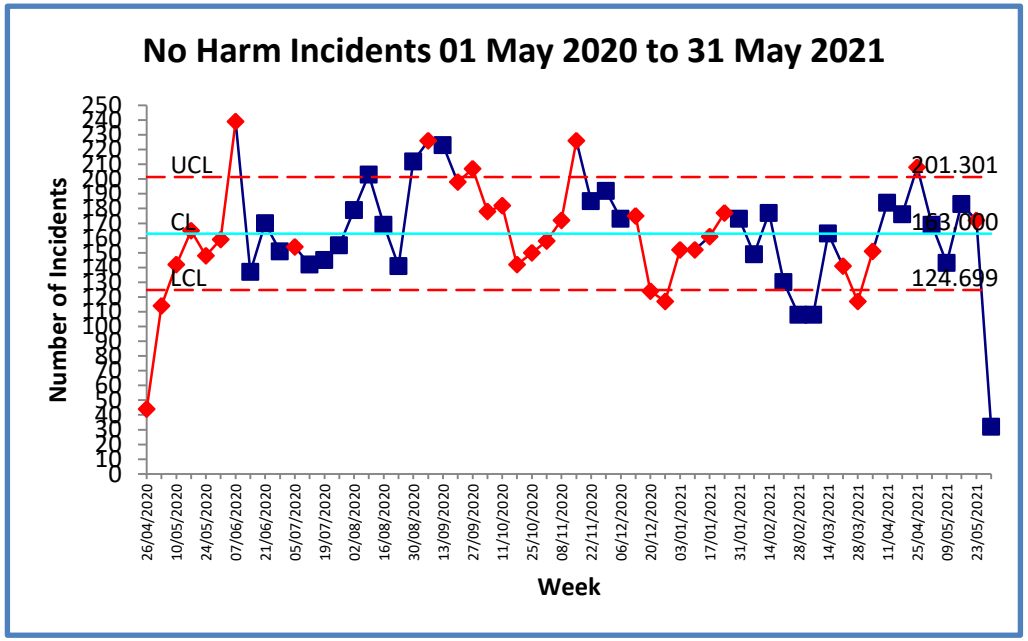
The Quality Oversight System continues to review all incidents and triangulate the contributory factors with other sources of intelligence. There was a theme relating to delay in critical medications. This was discussed through various forums, IPMG/QuOC/Medicines Nursing & Midwifery Forum and Medicines Safety Committee. Quality Improvement are to consider a project with the next intake of Junior Doctors. 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.

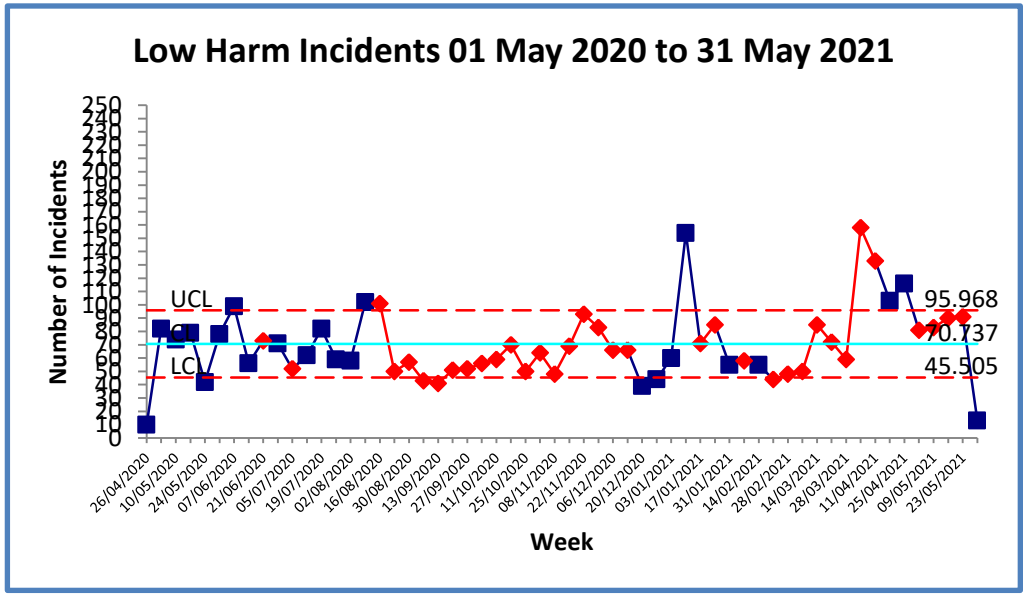
COVID specific incidents

Incidents relating to COVID are routinely reviewed at the daily risk huddle and in the context of the silver conference call. Specific incidents are escalated through IPMG and QuOC as required. There has been a decrease in the number of incidents related to COVID, which is expected.

Low and no harm incidents

The month of May saw a drop in the number of no harm and low harm incidents reported. However, when compared to May 2020, the figures are very similar. The Quality Governance and Quality Improvement Teams continue to look at various ways to extract free learning from low and no harm incidents and these are monitored through QuOC.





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. 2 Serious Incidents were declared in between 17th May and 13th June 2021. See SI paper for full detail.

SI2021/11701 (WR110620) Abuse/alleged abuse of child patient by third party
A child was admitted with a number of pressure ulcers and signs of significant weight loss.
This was logged by BTHFT for reporting purposes only and has been transferred to the commissioners for a system wide investigation.

SI2021/12145 (WR110868) Treatment delay meeting SI criteria
Delay in ophthalmic surgery which may lead to a less favourable outcome, level of harm is yet to be determined.

Immediate learning:
- Timely covid screening and clear communication with the theatre team and anaesthetist for acute theatres is essential for enabling timely access to acute theatres for time critical cases.

Patient Experience

- Complaints for May are 32 which is lower when compared to April
- PALs issues have increased from 142 in March to 163 in April and May
- Compliments have remained the same at 47
- Complaints - Main theme in May has been Care and Treatment issues with the sub-theme being appropriateness of treatment, which is the same as April
- Digestive Disease and General Surgery received the most complaints in May – 7
- 58 open Complaints at the end of May compared to 76 at the end of April
- No Complaints over 6 months

Patient Experience (continued)

May 2021: Patient Experience Contacts		Position from last month
Complaints received:	32	↓
PALS issues received:	163	→
Compliments received:	47	→

May 2021: Patient Experience Closed	
Complaints responded to:	51
PALS issues responded to:	183

May 2021: Complaints Received -Themes

Themes by Subject

	Total
Access to NHS services	2
Appointment	3
Attitude & behaviour	11
Care and treatment issues	24
Communication	11
Delay in diagnosis	7
Discharge	7
Discrimination	2
Food quality issues	3
Infection control	1
Medication	1
Patient procedure issues	1
Theft, loss or damage of personal property	1
Transfer	1
Visiting issues	1
Total	76

Top 9 themes by Sub-subject

	Total
Appropriateness of treatment	13
Unprofessional	11
Patient and/or relatives not being informed	6
Appropriateness of request	3
Care issues for vulnerable patients	3
Delayed diagnosis	3

May 2021: Complaints – by CBU

	Total
Access	1
Critical Care, Anaesthesia and Pain	1
Chief Nurse	1
Digestive Diseases and General Surgery	7
Elderly and Intermediate Care	4
Head and Neck	2
Musculo-skeletal, Plastics, Skin	2
Radiology and Imaging	1
Specialist Medicine	3
Urgent and Emergency Care	4
Urinary Tract and Vascular	3
Women's Services	3
Total	32

Patient Experience (continued)

May 2021: PALS Received

Themes by Subject

	Total
Admission	2
Access to NHS services	1
Appointment	36
Attitude & behaviour	24
Care and treatment issues	33
Communication	41
Delay in diagnosis	10
Discharge	8
Environment issues	5
Equipment issues	5
Food quality issues	1
Information security breach	1
Medication	3
Medical records issues	4
Patient procedure issues	10
Support Needs	1
Theft, loss or damage of personal property	10
Transportation issues	3
Visiting issues	4
Total	202

Top 9 Themes by Sub-subject

Appropriateness of treatment	19
Unprofessional	15
Patient information	14
Patient and/or relative having difficulty making contact with organisation	13
Loss of property	9
Delayed results	8
Appointment - Length of wait for an appointment	7
Appointment - Failure/delay in referral systems	6
Inappropriate discharge	6

May 2021: PALS by CBU

	Total
Access	12
Children's Services	8
Chief Nurse	3
Digestive Diseases and General Surgery	15
Elderly and Intermediate Care	12
Estates	2
Head and Neck	17
Haematology, Oncology and Palliative Care	2
Informatics	1
Musculo-skeletal, Plastics, Skin	11
Radiology and Imaging	11
Specialist Medicine	12
Therapies	5
Urgent and Emergency Care	27
Urinary Tract and Vascular	12
Women's Services	13
Total	163

Externally Reported Incidents May 2021

Incident date	Datix number	Incident details	Action and Learning
RIDDOR reportable incidents			
29/04/2021	WR109645 Ref: 125154D6A2	Injury preventing work or usual work tasks for more than 7 days. A cleaning assistant slipped and fell on new vinyl flooring whilst cleaning on a corridor on a ward. As a result they sustained a fracture of the arm. *It should be noted that although this incident has been reported to the HSE as an over 7 day incident, the staff member sustained a fracture; therefore, it should have been reported as a specified incident. This has been raised with the reporter of the incident.*	**Action** • Estates to investigate suitability of the vinyl flooring. • SOP for cleaning of a corridor floor area given to all cleaning staff **Learning** The learning will be available once the investigation has been undertaken.
01/05/2021	WR109699 Ref: 9A11C9F121	Injury preventing work or usual work tasks for more than 7 days. A staff member slipped on a wet floor in Emergency Department's temporary staff accommodation whilst entering the building from outside. At the time of the incident it was raining outside and it is believed the floor was wet due to rainwater being brought into the building. Additionally, there was no mat at the entrance to the temporary staff accommodation, to enable staff to dry their feet when entering the building.	**Action** • A suitable mat should be fitted at the entrance to the location. **Learning** All entrances to Trust buildings should be fitted with a suitable method (such as a mat) for people to dry their feet on when entering the building.
25/04/2021	WR109724 Ref: 149F714817	Injury preventing work or usual work tasks for more than 7 days. Whilst I was helping to clean a patient who had been incontinent, a staff member tripped over a zimmer frame at the end of the bed. The staff member fell to the floor, landing on their right hip. Following the incident the staff member felt dizzy when they stood up. The staff member took paracetamol and went to back to work as the department was busy	**Action** • Staff members reminded to where practicable de-clutter the area before undertaking a task. **Learning** Where practicable, staff should ensure they are undertaking tasks in areas that are free from clutter that could become a tripping hazard.
17/11/2020	WR104159 Ref: A6E8A51491	It is alleged that during a colonoscopy procedure the CO^2 canister ran out, a HCA attempted to find a staff member to change the cylinder. However, there was nobody available to do so. Knowing the procedure could not be completed without the CO^2 the staff member went to get a new cylinder but there were none within the unit. The staff member then found a cylinder attached to equipment in another room that was not being used and removed it to be exchange for the depleted one. Whilst removing, transporting and reconnecting the cylinder, the staff member injured their wrist.	**Action** • Staff members reminded to undertake a dynamic risk assessment prior to performing moving & handling tasks. **Learning** • Ensure there are spare medical gas cylinders available within departments. • Prior to undertaking a procedure, ensure that the medical gas level is sufficient to complete the procedure.

Externally Reported Incidents May 2021 (continued)

Incident date	Datix number	Incident details	Action and Learning
SHOT reportable incidents			
20.5.21	WR110418 External Agency's Ref: 2021/005/021/ HV1/002	Samples received in the Blood Transfusion laboratory on 20/05/2021. The ABO group was inconclusive and referred to NHSBT Barnsley Red cell Immunohaematology who confirmed the inconclusive ABO group. Fresh Frozen Plasma (FFP) was issued by the laboratory on 20/05/2021 at 22:02. The FFP issued was group O. As the patients ABO group is inconclusive, there is a risk that the FFP issued is ABO incompatible with the patients group. The BMS on duty realised that the incorrect ABO group FFP had been issued at 00:15 and telephoned the neonatal unit to speak to the neonatal registrar. The BMS asked the registrar to stop the transfusion. The neonatal consultant and haematology registrar on-call were contacted and made aware of the incident. The transfusion was stopped and further FFP requested. ABO compatible FFP issued by laboratory at 00:37 on 21/05/2021	**Action** In light of this incident and the omission to the two sample rule for neonatal patients, after consultation with appropriate medical colleagues, the laboratory have implemented the following with immediate effect: • Disposed of all FFP and Cryoprecipitate for Neonatal use other than group AB. • Only routinely stock group AB FFP and AB cryoprecipitate for neonatal use. • There is a notice on the FFP freezer with the new running stock levels. • SOP with the change to process and this SOP will be trained out to staff once published. **Learning** Group O FFP should only be given to group O recipients. Where the ABO group is inconclusive AB plasma should be selected.
Incident date	**Datix number**	**Incident details**	**Action and Learning**
PHE Screening reportable incident			
20/05/21	WR110378	A lady was sent home with a form that had another lady's details on it. 2 x procedures were done in the room that morning, 1 x VAB, 1 x 14 G Bx. Stickers from the first procedure got mixed into the second lady's report packet. When filling in the relevant post observations form for the lady, it seems the wrong sticker has been stuck on the form. Staff at the time didn't realise the error, it was only once the lady phoned the department when she was home and raised the incident.	**Action** • Lady apologised to and asked to destroy the sticker • Staff have checked both clients' report packets to ensure the correct stickers have been used, this confirmed all other documentation had the correct details • Manager has spoken with staff **Learning** • Staff have been reminded to be more vigilant.

Inquests – Regulation 28 Report to Prevent Future Deaths

INQ/ROBS - Inquest heard in March 2021 – Vascular/Orthopaedic/Plastics

Medical Cause of Death:
1a Necrotising Fasciitis
1b Recreational Intravenous Drug Abuse

The Coroner comments are not congruent with the findings of the Trust's own SI investigation, however a response is being drafted to respond appropriately to the comments that have been made.

June 2021 - SMR score (Data source: HED)

Figure 1.2: Funnel Plot (Rebasing period up to Mar-21)

Please note that the funnel plot is only valid when the overall HSMR score is around 100.

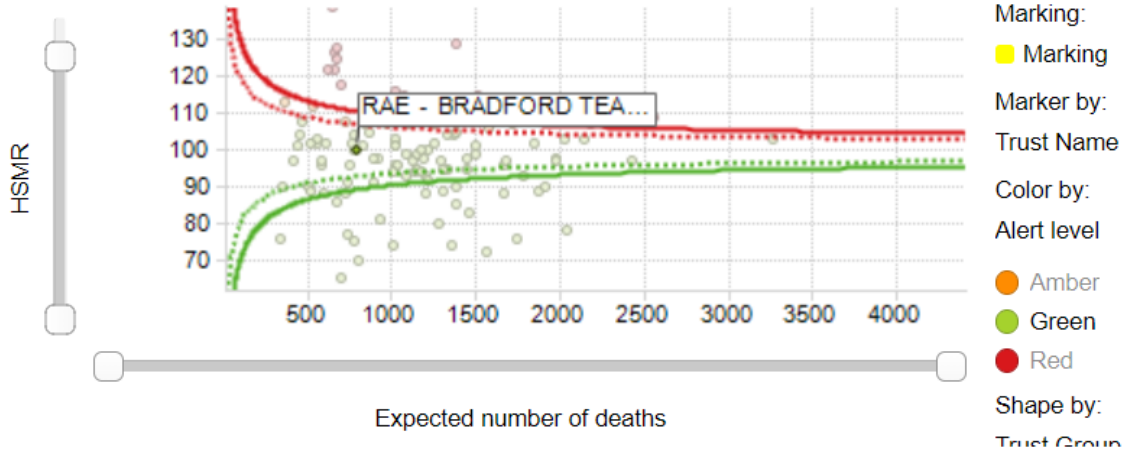
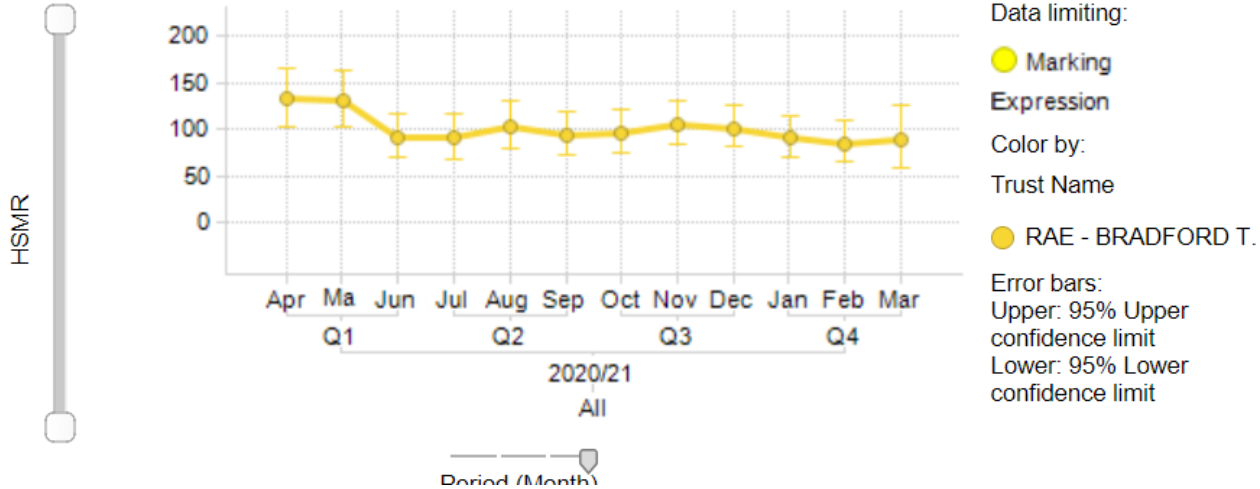


Figure 1.3: Time Series



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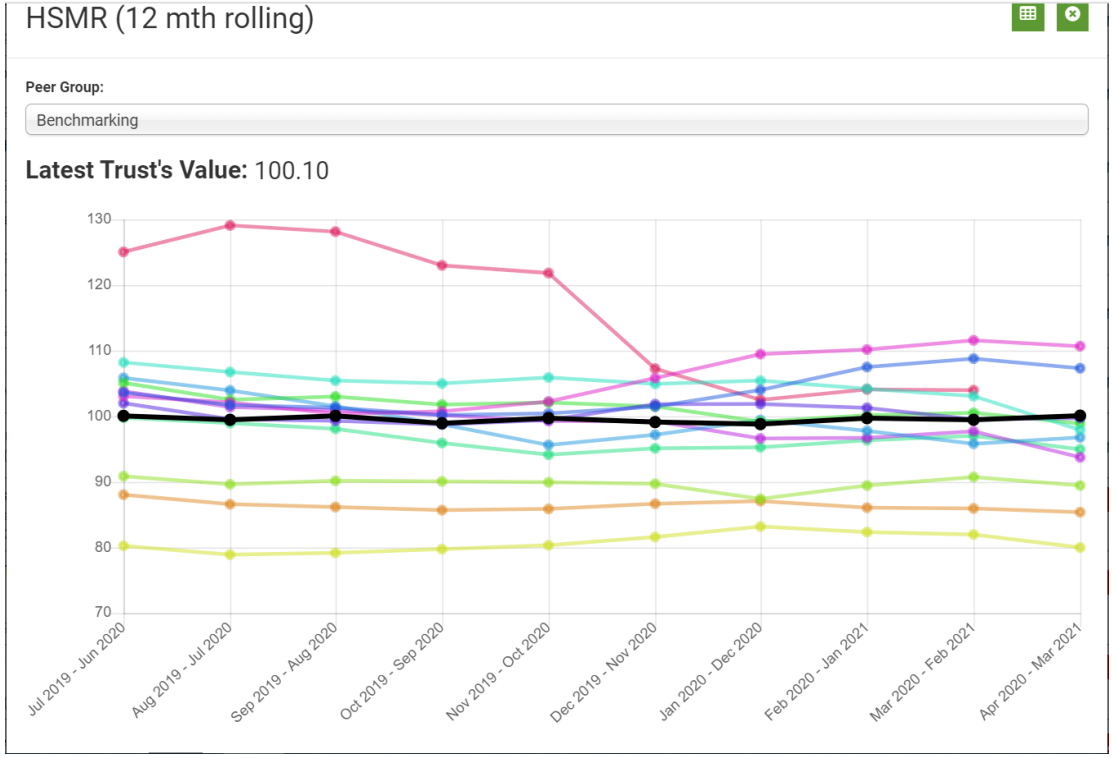

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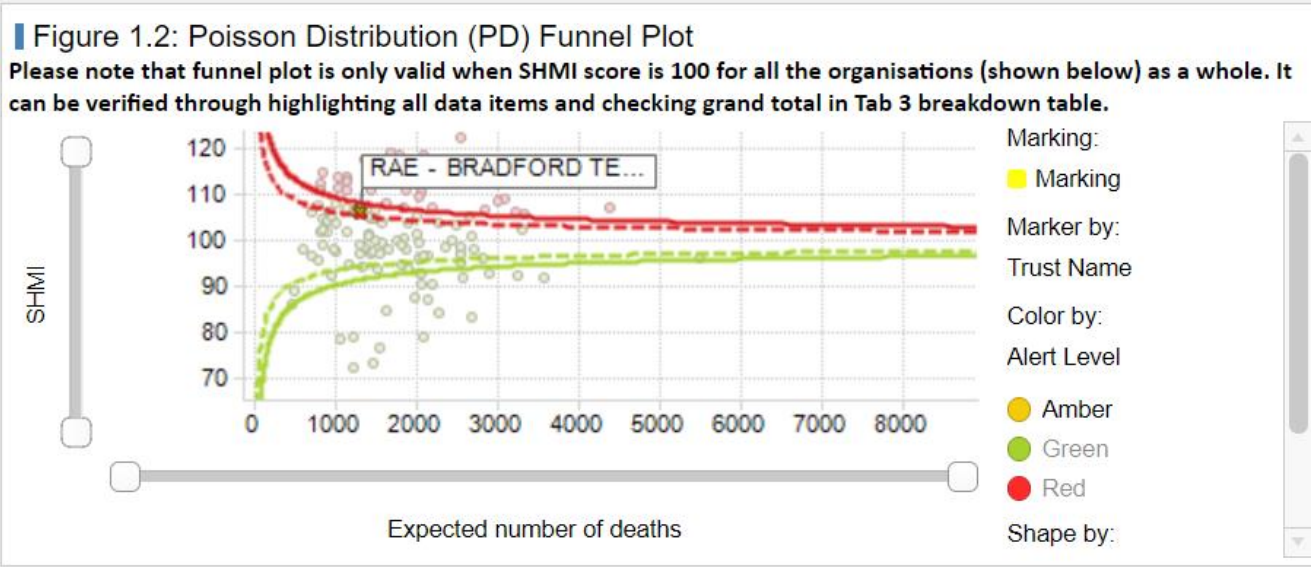
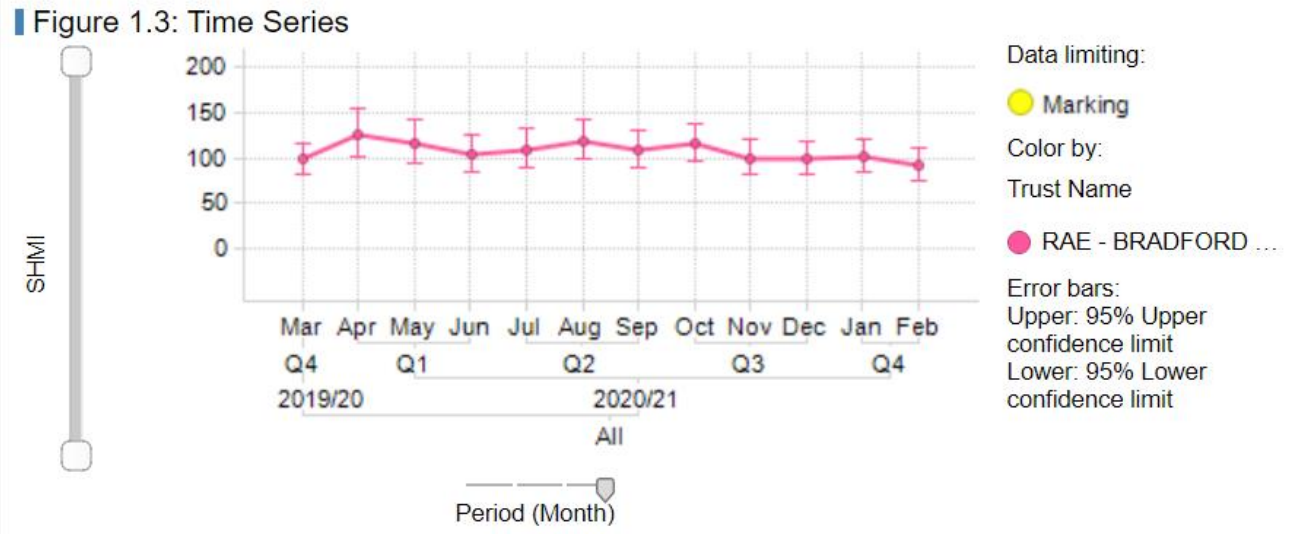
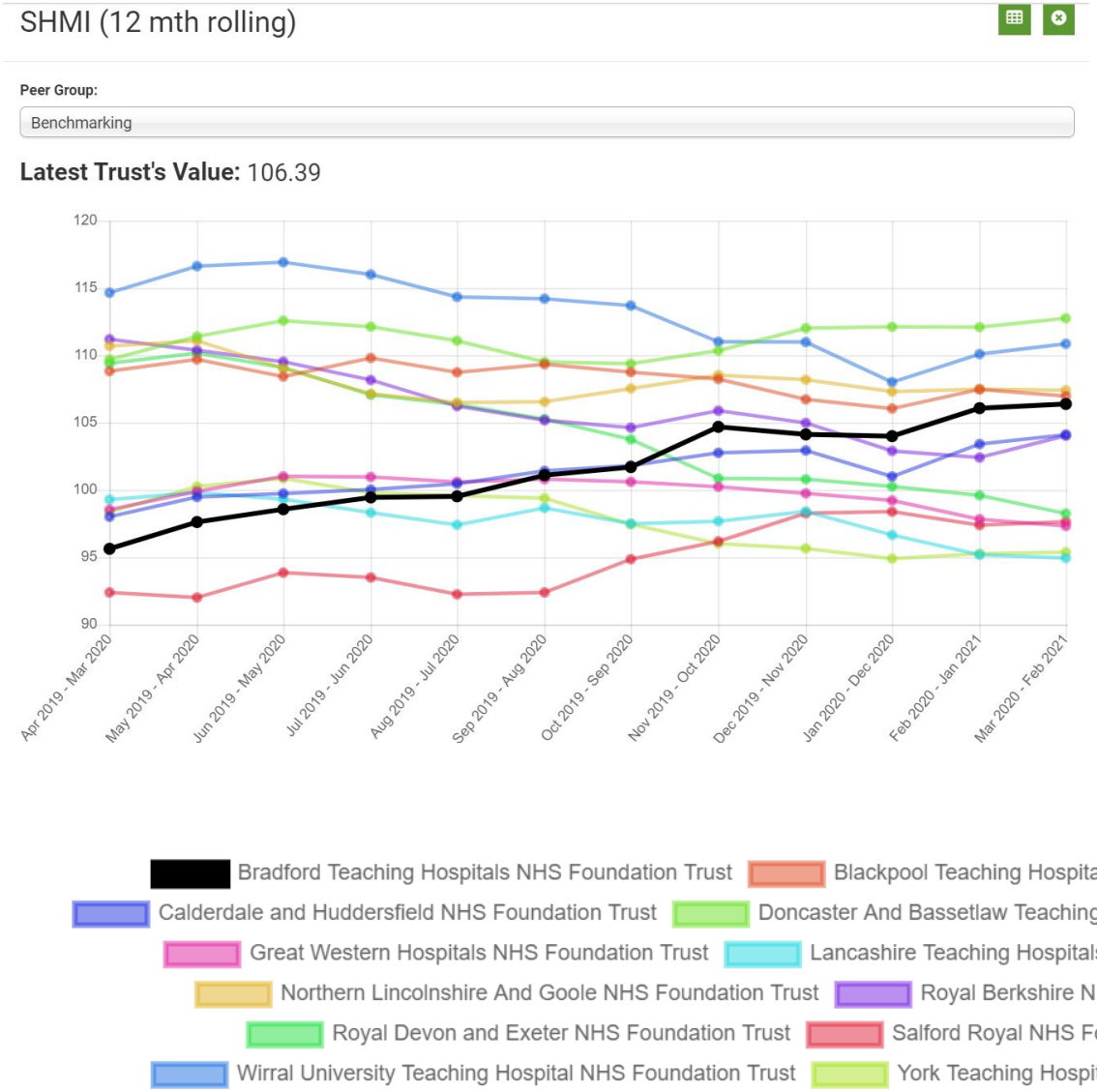
Great Western Hospitals NHS Foundation Trust
Lancashire Teaching Hospitals NHS Foundation Trust
Northern Lincolnshire And Goole NHS Foundation Trust
Royal Berkshire NHS Foundation Trust
Royal Brompton & Harefield NHS Foundation Trust
Royal Devon and Exeter NHS Foundation Trust
Salford Royal NHS Foundation Trust
Wirral University Teaching Hospital NHS Foundation Trust
York Teaching Hospital NHS Foundation Trust

June 2021 - SHMI score (Data source: HED)

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