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| <b>Meeting Title: Board of Directors</b> |                          |                     |                   |
| <b>Date</b>                              | <b>23 September 2021</b> | <b>Agenda item:</b> | <b>Bo.9.21.11</b> |

## Report from the Chair of the Quality Academy

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|--|---|------|--|
| Presented by   | Karen Dawber, Chief Nurse / Dr Ray Smith, Chief Medical Officer   |      |  |
| Author   | Jacqui Maurice, Head of Corporate Governance  |      |  |
| Lead Director  | Karen Dawber, Chief Nurse / Dr Ray Smith, Chief Medical Officer   |      |  |
| Purpose of the paper   | To provide a summary of the discussions and outcomes from the Quality Academy meeting held on 28 July 2021  |      |  |
| Key control  | This report is relevant to Strategic Objectives 1: To provide outstanding care for our patients, and 4: To be a continually learning organisation |      |  |
| Action required  | To note   |      |  |
| Previously discussed at/<br>informed by  | Quality Academy meeting held 28 July 2021   |      |  |
| Previously approved at:  | Committee/Group   | Date |  |
|  | N/A   |      |  |
|  |   |      |  |
| Key Matters Discussed  |   |      |  |
| <p>The Quality Academy met on 28 July 2021. Summaries of the key items discussed at the meeting are presented below. The confirmed minutes from the meeting held in July will be available at Board in November. The next meeting of the Quality Academy is scheduled for 29 September as there was no meeting held in August. Subsequent to the decision made at the Board of Directors in July 2021; Mohammed Hussain, Non-Executive Director, will take on the role of Chair of the Quality Academy from September 2021.</p>  |   |      |  |
| <b>Meeting held 28 July 2021</b>   |   |      |  |
| <b>1. Service Presentation – Update on Neonatal Deaths</b>   |   |      |  |
| <p>The Academy discussed a comprehensive presentation provided in response to reports received at the April and May meetings concerning neo-natal deaths, two of which were the subject of Serious Incident Investigations (SIs). A thematic review of the deaths was requested and undertaken by the Academy to provide assurance and identify the learning and actions that had been implemented in response. The learning and actions underway were clearly outlined in the presentation received and is fully documented within the minutes. The learning points from the SIs will be made available once the investigations are complete however there was good focus on communications and the exchange of information during shifts. It was expected that the Outstanding Maternity Services and Cerner Maternity Implementation could lead to easier provision of valuable information to the Neonatal team on patients in the Delivery Suite. There was discussion of the delivery room huddles and the relaunch of the Joint Safety Huddles to further improve communication between teams was well received. The positive strengthening of network communications was also noted, in particular the plan to provide external reviewers from other Neonatal Units. The learning from the SIs would be considered once the investigations had been completed. The Academy was suitably assured by the report received and the detailed discussion held particularly given the sensitive nature of the subject matter.</p> |   |      |  |
| <b>2. Quality Oversight &amp; Assurance Profile</b>  |   |      |  |
| <p>The information presented in this report received is reviewed weekly by the Quality of Care Panel and supports decision making and the sharing of best practice. The Academy noted the following key extracts from the report received.</p>   |   |      |  |
| <ul style="list-style-type: none"><li>• The oversight slide is replicated weekly at the Quality of Care Panel (QuOC).</li><li>• A theme concerning equipment and the maintenance of equipment has been identified.</li></ul>   |   |      |  |

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currently monitored through the Patient Safety Group.

- Six CAS alerts have been received, four requiring a response.
- Five incidents have been reported under the Reporting of Injuries, Diseases and Dangerous Occurrence Regulations (RIDDOR) for staff, pertaining to for example staff injury, slips and falls.
- One incident has been reported to Serious Hazards of Transfusion (Blood Transfusion Regulator).
- One incident has been raised regarding Quality Assurance in the screening service. The Trust was alerted by a patient that they had received a letter with only a partial result. On investigation this was a system error, this was rectified immediately with no harm identified and immediate actions taken.
- Admissions to four claims regarding breach of duty of care have been made. Four further claims have been referred to NHS Resolution.
- Twelve SIs are currently registered on the STEIS system, three reports are in the final stages of closure.
- Since the publication of the report there has been a Serious Incident relating to the surgery of a young child who required further intervention from a vascular perspective. The child was transferred and remains under the care of Leeds. The Academy was fully updated on the case.
- 48 complaints, 182 Patient Advice and Liaison Service (PALS) issues and 76 compliments were received in June. 36 complaints and 163 PALS issues were responded to. Complaint issues continue to be monitored. The Academy noted here in particular that the higher level of complaints may be due to public tolerances reducing following the Covid Pandemic. There were no overall themes emerging however it was clear that there were frustrations evident due to Covid restrictions. Areas highlighted were delays for procedures, waiting times and issues with regard to visiting.

### 3. Strategic Risks relevant to the Academy

Risks were reviewed and the following key points and actions were noted from the discussions.

- 3603: Threat of Brexit. The score had been reduced and therefore this risk had now been de-escalated from the Strategic Risk Register.
- 3560: Staff absences in relation to the Covid App. This risk was discussed at People Academy on 28 July 2021 and has been remodified with updated guidance to assist in the control of the 'pingdemic'. Only a minimal amount of staff have benefitted from this action.
- A number of risks are noted to be past their review dates and these would be considered by the Executives and updated.
- There were a number of risks around Covid and the Academy did wonder if these should be merged in some way. On reflection it may be that all interdependencies should be grouped together going forward following lessons learnt from experiences. This would be considered by the Executives.

### 4. Safeguarding Adults and Children: Annual Reports

The two reports were received by the Academy. The importance of training and support was emphasised and further noted that safeguarding training was mandated across the Trust. The Chief Nurse has requested an update to be provided to the Academy in September on mental health, the risks and the potential impact on the organisation.

### 5. Patient Safety Group

The following key outcomes are highlighted from the discussion held.

- The procurement of 'human factors' training in line with the Education team have recently procured some human factors training suitable for all staff in line with the national patient safety strategy. *(Human Factors training differs from traditional safety training in that the focus is on*

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*the cognitive and interpersonal skills needed to effectively manage a team-based activity rather than the technical knowledge and skills required to perform specific operations).*

- Improvements in EPR functionality enabling the electronic flagging of patients with significant disease including diabetes and Addison's disease.
- Implementation of ward based training in the acute medical admission areas regarding documentation of neurological observations.
- An incident relating to a number of duplicate CT examinations has been reported to the Care Quality Commission (CQC) and Ionising Radiation (Medical Exposure) Regulations (IRMER) due to the identification of a common theme as the cause. The processes involved have been reviewed within Radiology and assurance provided on improvements in place.
- Recent National Patient Safety Alert (NPSA) received around the identification of equipment which has the risk of foreign body aspiration at the time of intubation. For assurance purposes, Theatre and Procurement teams are working together to ensure robust processes are in place to procure different equipment to reduce the risk of this type of incident.
- A review of incidents relating to delays in the administration of critical medicines has been undertaken. Several areas of improvement work have been identified which will benefit from the support of the newly appointed Medicines' Safety Officer.

## 6. Clinical Outcomes Group

The response to the pandemic has impacted the clinical outcome assurance work here at the Trust. This work is coming back to the fore and the Academy received an overview of the priorities and actions undertaken. The Academy was pleased to note that the group is sighted on:

- The Annual National Clinical Audit plan which commenced in April 2021, comprising 29 mandatory audits.
- Three mandated National Confidential Enquiries into outcome and death are currently in the planning phases.
- There is ongoing work to understand the scope of the current National Institute of Clinical Excellence (NICE) guidance, working with specialties to understand any risks.
- The Clinical Outcome Group (previously Clinical Audit and Effectiveness Subcommittee) is being reformed. Interviews for an Associate Medical Director for Clinical Outcomes will be held in the next few weeks and it is expected that this person will drive the agenda forward.
- Further areas of work have been identified and a work plan is being devised.
- Engagement work continues with the Clinical Business Units with a refocus on consideration of good clinical outcome measures to drive improvement.

The Academy heard that as governance recommences appropriate support to the Clinical Business Units will be paramount from a quality perspective to include outcome, safety and experience.

## 7. Learning from Deaths (Healthcare Onset Covid Infection)

'Hospital onset Covid infection' (HOCI) meets the definition of a patient safety incident. As such it was appropriate to undertake Serious Incident investigations. Owing to the number of cases, and in line with the NHS Patient Safety Strategy, a cluster of SI investigations were undertaken, in agreement with the Clinical Commissioning Group (CCG). A key aspect to the study was the response and containment of the virus in the organisation with rapid learning from data to help prevent and reduce the risk of transmission within the Trust. Despite the learning and measures instigated to prevent infections 18 cases were identified. The Academy heard about the actions undertaken and the review of outcomes and learning in order to seek to prevent transmission of infection and to understand how the disease spread during the height of the pandemic. From the patient data particularly in the early part of the pandemic, patients clinically had Covid but this did not show on testing. Patients may have been discharged testing negative but were then readmitted testing positive. Covid 19 is not MRSA and thus not avoidable by taking Infection, Prevention and Control precautions, it is an airborne disease and unavoidable.

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To have kept numbers to the level has been a remarkable achievement and it would appear deaths suffered by the organisation were as far as is evidenced unavoidable. With regard to treatment and deaths, Bradford has led nationally on not intubating and ventilating immediately, as in other parts of the world. Bradford was one of the first organisations nationally to use NIV and CPAP and patients were only intubated as a last resort. On reviewing mortality intubation statistics, Bradford had a lower incidence of intubation. Avoiding intubation is now the standard of care nationally.

Regular updates will be provided to the Academy and consideration is being given to including this information on the dashboard.

## 8. Outstanding Theatre Programme

As previously reported there are long standing issues within the Trust's Theatres. The culture has been thrown into the spotlight more recently as we focus on staff recruitment, retention, morale and team ethos. Theatre staff have also been relocated to the Intensive Care Unit during the pandemic, however, in order to address the waiting lists a core focus is now required on the productivity of theatres.

An Outstanding Theatres plan is being introduced (following the success of the Outstanding Maternity Services project (OMS)). Following an initial meeting positive feedback was received and reassurance provided in relation to the concerns of the theatre staff - similar to those concerns raised at the start of the OMS project. Regular updates will be provided over the next six to twelve months on the developments. The Outstanding Theatres Plan will be led by Dr Debbie Horner, Consultant in Anaesthesia and Critical Care/Deputy Operations Medical Director, from a transformation and clinical perspective, and Tim Gold, Director of Operations, from a project development perspective. Time will be required to process developments in productivity. The importance of a cohesive team will be essential to the plan's success which aims to result in major long-term gains including the recruitment and retention of theatre staff.

## 9. Interim Effectiveness Review of Quality Academy

The Academy noted the comments received and the further ongoing work required around the timing and balance of the agenda discussions. The Academy noted the changes with regard to the Regulation and Assurance Committee and that from September the meeting Chair would be one of our Non-Executive Directors. The revised Terms of Reference will be submitted to the September Quality Academy reflecting the new reporting arrangements.

### Items of Positive Assurance, Learning and/or Improvement

Many of the reports received and discussions held feature elements of assurance, learning and improvement. In particular however, as Chairs of the Academy, we would like to highlight from this month's meeting:

1. Service Presentation – Update on Neonatal Deaths
7. Learning from Deaths (Healthcare Onset Covid Infection)

The Board is asked to note the discussion on risks and also the focus of the discussions under 2. Quality Oversight & Assurance Profile. Whilst we don't have a finalised dashboard as yet we are still cognisant of our key performance indicators. The Academy has discussed risks in detail and considered any mitigating actions that may be required.

### Matters escalated to the Board of Directors for consideration

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There were no matters to escalate to the Board however the Academy would like the Board to particularly note the establishment of the Outstanding Theatres Plan.

#### **New/emerging risks**

There are no new risks however the Academy is aware of those risks it considers alongside other Academies.

#### **Recommendation**

The Board of Directors is requested to note the discussions and outcomes from the Quality Academy held on 28 July 2021.

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## Key Matters Discussed

### Meeting held 30 June 2021

#### 1. Focus on Sepsis

Academy provided with sight of the new Sepsis dashboard launched on 26 April which they are trialling. The dashboard provides a single source of real time information provided within 24 hours rather than as previously on a weekly or monthly basis. Information is broken down to ward level. And supports daily engagement with medical teams particularly with regard to patients not screened within 24 hours. The good news is that compliance is rising and the daily contact alongside this new dashboard providing real time information is making a difference.

Last four months our Trust was averaging 69% of patients being screened which is down on last year where it was 75%. Now looking at sharing the dashboard at ward level to collect the time to treatment in line with the evidence and NICE guidance as can see which areas are not doing so well. The Academy also noted that embedded within the dashboard is all of the patient information so they now have the ability to see if the patient is receiving the correct antibiotics in line with Trust policy.

The averages over the last four months for the delivery of antibiotics within the hour sit at 86% and within four hours it is just over 90%. The team is aiming to achieve 90% for within the hour. Academy noted that the team is only able to look at 'time to treatment' for those patients who have been screened and need to ensure continued improvements in the screening rates.

Team wish to adopt the dashboard as a single source of information. The daily data is more powerful as well as the ability to respond to it in line with NICE guidance. Another benefit is that changes to the reference data can be reflected within 24 hours which provides more accurate data and supports a better patient experience. An update will be provided back to the academy in November.

The group focussed on the projects underway in relation to Quality Improvement. The Academy covered some of the more difficult aspects of ensuring compliance and in particular cultural barriers that were in place. They noted that Planned Care was not as compliant as they could be. This has been identified as a focus of one of the improvement projects. It was suggested that one of the issues may be staff recognising the relevance of this piece of work. Part of that might be looking at the membership of the academies to include more medical representation.

Chief Nurse and the Chief Digital and Information Officer, alongside other key informatics staff will meet to explore how to better engage with staff to understand the importance of Brilliant Basics.

#### 2. Quality Dashboard

The Academy noted the detailed review taking place with regard to the dashboard measures and that the agenda features a number of items in greater detail.

#### 3. Quality Oversight and Assurance Exception Profile

In particular the Academy noted the following key items:

- The recent appointment of an Associate Medical Director for Mortality and Learning from Deaths. Work underway to understand the data more, and use information gleaned from structured judgement reviews to support learning. Included within appendices some of



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external learning and recommendations undertaken in relation to the recent HSIP report published in relation to Maternity which has made changes in response to the report.

- Regulation 28 notice was issued to the Trust in relation to an inquest held at the end of June/early July. A response is in the process of being drafted to comments made by the Coroner.

#### 4. Strategic Risks relevant to the Academy

The Academy discussed risk 3380 which relates to patients with a mental health diagnosis not receiving appropriate treatment had changed in score from 20 to 16. Since that change the Trust has seen an increase in number of related incidents and it is likely that it will move back to 20. To further mitigate the risk the Chief Nurse has a meeting scheduled with colleagues at the BDCT as a matter of urgency in relation to the increased numbers of patients attending our Trust who are acutely unwell and presenting with complex mental health issues.

#### 5. Quality Account 2021

Academy members (and Board members) had previously been in receipt of the draft Quality Account on 18 June. Some feedback was received. Key was a need to include within the report reference to Equality, Diversity and Inclusion. Following discussion the Academy agreed to include reference to EDI developments over the last year as an adjunct to the Chief executive Statement on Quality and, include an additional Improvement Priority in relation to EDI. The Chief Nurse, Deputy Chief Medical Officer Quality and the Head of Equality, Diversity and Inclusion would meet to confirm content by close of Thursday 1 July. The Academy noted that the report would be provided to our External Stakeholders on 2 July with a response required by close of 12 July and that the final version of the report would be presented to the Board for approval on 22 July 2021.

#### 6. Patient Safety Group

The key points noted from the comprehensive monthly patient safety group.

- In relation to the risk highlighted earlier for patients with mental health conditions; the patient safety group are in the process of investigating a cluster of related incidents. They have however presented some early learning to the Patient Safety Group and have noted that it is mainly the admission areas where these problems are materialising; they involve poor behaviours and assaults on NHS staff. There is some work to do on pathways, policies and tools used. Additional learning relates to training in restraint for some staff groups and the provision of more support for staff in form of body cameras for security staff.
- Form an improvement perspective; the education team is developing human factors training to be made available to all staff (*Human factors are those things that affect an individual's performance. A human factors approach is key to safer healthcare. It will become part of the core curricula of all health professionals*).
- Noted that children's services being a hotspot for mental health issues and requested to be included with regard to any learning. Key join all together.

#### 7. Infection Prevention and Control (IPC) Quarter 1 report

Comprehensive report and presentation delivered. Key points to note.

- Have robust MRSA improvement programme for 2021/22. As part of the programme work is underway with the vascular team as last year this was where the increase in MRSA cases was seen.
- A thematic analysis regarding MRSA cases was provided and work has been undertaken with

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the care groups to improve audit, education and feedback.

- For specific infections such as C.Difficile we remain fairly low in the national picture and for MRSA we are an outlier.
- An Infection Control Nurse is now working full time as a train the trainer and this is working well and we are setting up nurse led C.Difficile ward rounds – a programme replicated in other Trusts to see if this is an effective way to support clinical teams.
- AMS Audit has been undertaken. The IPC team is working closely with the antimicrobial pharmacist and biologist. An antimicrobial forum has been restarted to drive improvements.
- National standards for cleaning have been revised and published. A working group is being established by the Facilities Management Team. This will involve additional risk ratings and star ratings will have to be displayed on every ward and department. There are huge implications for the facilities cleaning team and the Trust as a whole. We are legally obliged to have the star ratings and we have 12 months to implement them.

## 8. Serious Incident Report – May 2021

In the last month we have declared two new SIs. One is in relation to system wide investigation regarding a child safeguarding case. Up to now we have not identified any early learning for our Trust. The second SI relates to a delay in Ophthalmic Surgery. There has been some early learning in relation to how we organise and communicate about our acute theatre sessions and the slots available to individual specialties and that has been actioned.

Two SIs have been closed and a summary of these are included within the paper. Both identified some learning for us and this is included within the paper. There have been no duty of candour breaches and no Never Events this month.

## 9. Patient Translational Research Centre Patient Involvement in the investigation of Serious Incidents (SI)

Comprehensive presentation provided by Professor Jane O'Hara.

- The project concerns developing and testing new processes and guidance to better support patients and families in SIs. Have taken account of EDI.
- Working with four trusts as part of the programme (two mental health trusts and two acute trusts).
- Will come back to the Academy and feedback on progress in six months.

The Academy is excited to be involved in this work and moving forward would like to not only involve patients in SI but other wider improvement work. The Chief Digital and Information Officer suggested certain elements would translate into discussions taking place with regard to the new Corporate Strategy and the development of a Just Culture. Professor O'Hara cautioned that the approach would need careful managing to ensure that all stakeholders were recognised. She would be content to inform our discussions.

## 10. Learning from Deaths (Healthcare Onset Covid Infection)

This item was deferred to the July Quality Academy.

## 11. Research in the Trust – June 2021

Key highlights noted were:

- A great deal of national research was led by teams here in Bradford.
- Bradford Institute of Health Research (BIHR) was one of three patient safety translational research centres in country.
- Have an extensive program of applied research and a focus of implementing research.



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- The report promotes the benefits of research to staff, patients and students and, there is evidence that the hospital is participating more substantially in research and getting better patient outcomes as a result.
- BIHR is always seeking to strengthen its connections with the Trust and reaffirms its interest in building better connections with the clinical work underway at the Trust.

## 12. Maternity Services Update

Comprehensive report. Key points to note

- Have uploaded assurance to the national maternity team around the Ockenden submission. The team met the deadline and are pleased with the quality of information pulled together.
- Few additions to the paper as result of having to implement the new perinatal model. Trust Boards are required to review on monthly basis.
- Saving babies lives care bundle; part of maternity service incentive scheme and achieved full compliance following submission to Yorkshire and Humber team.
- There was one still birth in May
- Although not part of maternity remit note that number of neonatal deaths in May. Deep dive into those cases and see if any trends need to be aware of. Outcomes of deep dive will be presented in July.
- Escalation policy under review and is out for comment and should be ratified soon
- Unit met ACSA standards for Maternity. The team are fully compliant and meet the standards for safety 4 of maternity incentive scheme.
- Safety Champion walk arounds: The Academy needs to be aware of the intelligence that comes from ward to board level. There are no safety issues to escalate during May. Chief Nurse received positive feedback during her last visit.
- Improved process on feedback on safety information from staff on the ground.
- Improvement work showing good progress on all five work streams.
- Revised labour ward handover
- Created wellbeing sub-group from workforce work stream
- Cerner programme progressing

Paper will be presented to Trust Board.

## 13. Bi-Annual Digital Report

This item was deferred to the July Quality Academy.

## 14. Magnet4 Europe

Update received on developments with the Magnet4 Europe Initiative.

- Undertaken gap analysis which was submitted in March in conjunction with twinning partner
- Baseline survey complete. BTHFT response rate less than hoped for. Aiming for 200 and achieved 175 (similar position to other organisations).
- Now developing the action plan for delivery including regular communications that cover the principles of magnet to build into all we do
- Focus is on culture change, engagement and decision making. Recognising this about excellence in Nursing Care and impact on other members of team.

## 15. Estates and Facilities Quarterly Service Report

New quarterly reporting from estates covered four key themes in detail. The key points to highlight are

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- Improving the environment: Capital programmes were highlighted including the new staff changing facilities and the work ongoing in Maternity and at ENT Theatres.
- Governance: Estates and Facilities have had a number of internal audits undertaken which have reported high and significant assurance. EMT has also agreed the new 'ward to board' Estates and Facilities governance structure. The dashboard presented to the Academy forms part of this reporting.
- Workforce improvement and engagement. Apprenticeship programme is thriving and there has been a successful integration with the non-clinical risk team.
- Improving and enhancing operational services: Additional wheelchairs and trollies have been purchased to enhance patient flow. Also highlighted was the clinical engineering work trialling system to track all medical devices.

### Items of Positive Assurance, Learning and/or Improvement

Many of the reports received and discussions held feature elements of assurance, learning and improvement. In particular however, as Chairs of the Academy, we would like to highlight from this month's meeting;

- The Sepsis presentation and the improvements from having access to real time data
- The Patient Translational Research Centre Patient Involvement in the investigation of Serious Incidents
- The continued improvements and learning in our Maternity Services and the increase in
- And the very useful presentation from Estates and Facilities

The Academy also agreed to share this and future Chair Reports with other Academy members and sub group members.

The Academy did note the actions in place with regard to risk 3380 and the fact that it would most likely move back to 20 from 16 and in particular the reporting under the patient safety group on their focus on the mitigations in relation to this risk

### Matters escalated to the Regulation & Assurance Committee for consideration

The Academy would like to highlight the increase in neonatal deaths as referenced in the report on Maternity.

### New/emerging risks

There were no new or emerging risks.

### Recommendation

The Regulation and Assurance Committee is requested to note the discussions and outcomes from the Quality Academy held on 28 April 2021.