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

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/ informed by | Quality Academy meeting held 28 July 2021 | | |
| Previously approved at: | Committee/Group | Date | |
| | N/A | | |
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| 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> | | | |
| Meeting held 28 July 2021 | | | |
| 1. Service Presentation – Update on Neonatal Deaths | | | |
| <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> | | | |
| 2. Quality Oversight & Assurance Profile | | | |
| <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">• The oversight slide is replicated weekly at the Quality of Care Panel (QuOC).• A theme concerning equipment and the maintenance of equipment has been identified. | | | |

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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.