

Meeting Title: Board of Directors			
Date	18 November 2021	Agenda item:	Bo.11.21.9

Report from the Chair of the Quality and Patient Safety Academy

Presented by	Mohammed Hussain, Non-Executive Director, Academy Chair		
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Lead Directors	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 and Patient Safety Academy meeting held on 29 September 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 and Patient Safety Academy meeting held 29 September 2021		
Previously approved at:	Committee/Group	Date	
	N/A		

Key Matters Discussed

The Quality and Patient Safety Academy met on 29 September 2021 under its new name approved by the Board of Directors on 23 September 2021. Summaries of the key items discussed at the meeting are presented below. The confirmed minutes from the meeting held in September will be available at Board in November. The next meeting of the Quality and Patient Safety Academy is scheduled for 27 October.

Meeting held 29 September 2021

The Academy agreed that at future meetings, the agenda would be rearranged to provide a focus on learning and improvement at the beginning of the meeting. Members of the Academy will be invited to attend a development session to identify future areas of focus for the Academy.

1. Quality Academy Dashboard

Efforts had been made to improve the Quality and Patient Safety Academy Dashboard, however further work was required to establish what measures were to be included. Proposed changes would be presented at the next meeting for discussion. From the current iteration of the dashboard the Academy noted that;

- the Trust was identified as an outlier in the number of category 3 pressure ulcers reported. This was largely due to the extensive use of non-invasive ventilation during the COVID-19 pandemic.
- Work was ongoing with the Informatics Team to make the completion of the Electronic Patient Record (EPR) system easier for clinicians when caring for patients.
- The Trust reported as 'amber' for 'sepsis percentage of patients screened', however assurance was provided that no patient had a delay in treatment.

2. Quality Oversight & Assurance Profile

The information presented within the report received was reviewed weekly by the Quality of Care Panel and supports decision making and the sharing of best practice. The Academy discussed and noted the following key extracts from the report received:

- A highlight report would be received at future meetings to include a holistic approach to

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incident management within the Trust. A new approach would be developed to triangulate information from a number of sources including complaints, incident reports and coroner's reports as part of the quality improvement programme.

- During July and August the Trust reported eleven externally reportable incidents: two under the Reporting of Injuries, Diseases and Dangerous Occurrence Regulations (RIDDOR), five incidents reported under Serious Hazards of Transfusion (Blood Transfusion Regulator), three incidents reported under the Medicines and Healthcare products Regulatory Agency (MHRA) and one reported under the Screening Quality Assurance Services (SQAS).
- Learning from claims and inquests continued to be shared across the Clinical Business Units (CBUs). Inquests had been suspended during the COVID-19 pandemic, however they had recently recommenced.
- During an inquest heard at the start of September 2021, the Coroner had identified some issues and requested a formal response. The Trust was collating the additional evidence and liaising with radiology, gynaecology, histopathology and oncology.
- Getting It Right First Time (GIRFT) data had been shared with CBUs to review their own data.

3. Serious Incident Report

Three serious incidents (SI) were declared between 12 July and 12 September 2021. One was reported as a Never Event and related to the transfusion or transplantation of ABO-incompatible blood components or organs. No harm was brought to the patient. The second SI related to the surgery of a young child who required further intervention from a vascular perspective. The child was recovering well and a review of the SI was underway. The final SI was due to the delay of recognition in a deteriorating patient, which led to the patient developing sepsis and requiring surgical intervention. In accordance with the requirements of the Healthcare Safety Investigation Branch (HSIB) one maternity incident was reported via STEIS and, an independent investigation would be carried out by HSIB.

Six SIs had been concluded during the period with reports signed off, and internal action plans agreed which would be monitored via the Quality of Care Panel. Learning identified from incidents has been cascaded to relevant teams.

4. Strategic Risks relevant to the Academy

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

- Risk 3203 had been closed and replaced with a new risk: Risk 3696 relating to the age and condition of the pharmacy aseptic unit. Initially rated as 20, the risk had since been downgraded to 15 following mitigations.
- No risk had passed its review date.
- Many of the highest rated risks were shared with other Academies and were either directly or indirectly connected to the COVID-19 pandemic.
- An update was required against Risk 3104 (risk of failure of the telephony system) at the next meeting.

5. Internal Audit Update

The Academy received a report detailing the completion of the following audit reports.

- High assurance with no recommendations was received for the audit into Infection Control – PPE.
- The Freedom to Speak Up audit received significant assurance with three minor recommendations, which would be implemented by March 2022.
- The Safeguarding Children audit received high assurance with two minor recommendations.
- Since the publication of the report, the Claims Management audit received significant

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assurance with one recommendation.

6. Patient Safety Group

The following key outcomes were highlighted from the discussion held:

- The Patient Safety Group meets monthly with representatives from CBUs and safety critical areas. Learning had been discussed from three serious incident reviews and a presentation had been received following the National Falls Audit. Checks had been strengthened for staff and patients before entering an MRI room following a near miss incident.
- The Bradford Safety Standards for Invasive Procedures (BradSIPPS) Task and Finish Group membership had been extended to include the Patient Safety Specialist and a Clinical Lead. A central database was being developed.
- Fall guidelines had been updated which extended the use of alarms and cocoon mattresses to prevent falls.
- The Trust continued to work with partners to support staff when patients present with challenging behaviours. Progress had been made against the Trust work stream to reduce violence and aggression in the workplace. This was linked to the staff survey outcomes from 2020.

7. Infection Prevention and Control Board Assurance Framework

The following key outcomes were highlighted from the discussion held:

- National and regional investigations were commissioned to identify the factors that may have contributed towards the transmission of hospital onset of COVID-19 within acute hospital settings.
- In line with NHSE guidance, a review of the Trust's COVID-19 outbreaks during 2020/21 was undertaken to identify any further learning, which identified that there were two cluster types: COVID-19 hospital outbreaks, and hospital onset COVID-19 deaths, which had previously been reviewed by the Academy.
- The Trust declared twenty COVID-19 outbreaks, four of which involved staff only during the period of June 2020 to May 2021.
- In addition to national and regional learning identified, the Trust identified further learning which indicated that factors contributing included atypical presentation of COVID-19 in hospitalised older adults, socialising outside of the Trust premises specific to renal patients, inter-hospital transfers had been necessary to maintain service provision and that the majority of the Trust's clinical and non-clinical estate relied on natural ventilation.
- The Trust was reported nationally as 21 out of 125 Trusts in the prevention of management of outbreaks with a low rate of hospital onset of COVID-19.
- During August 2021 the Trust reported 0% of patients had been diagnosed with COVID-19 between day 8-14 following admission, and 2.4% of patients diagnosed with COVID-19 fifteen days post-admission.

8. Maternity Services Update: Outstanding Maternity Services Programme

The Outstanding Maternity Services (OMS) programme report was shared which highlighted:

- Good progress had been made on the programmes of work aligned to the five work streams: Investing in our workforce, moving to digital, linking learning, the women's journey and building fit for the future.
- A six-month celebratory video had been devised to celebrate the work achieved, and to share more widely with the Trust.
- All work streams and programme dashboard were public facing and had been shared with the

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Maternity Voices Partnership.

- 32% of the workforce had been directly involved in the OMS programme.
- 100% of the work streams had received input from service users.
- Engagement at team and department level continued to facilitate the aspiration towards the achievement of outstanding using the 'floor to board' principle.
- All areas were supported to be innovative and to capture their change ideas.
- Endeavours would be made to align the OMS programme and working in partnership.
- Learning from the implementation of the OMS had been shared more widely and had contributed to the growth of the Outstanding Theatre Programme which would be launched imminently.

9. Introducing the Electronic Patient Record (EPR) into Maternity Services - Update

Work commenced in spring to align Maternity Services with the rest of the Trust with using the same EPR system. The benefits will provide:

- The use of a single system within Women's Services with Trust wide access for the oversight from other specialities.
- The ability to capture data in relation to intrapartum workflows
- Real time integrated CTG into the patient record store indefinitely
- Improved mandatory reporting for the Maternity Services Data Set
- Better access to personalised care plans for women
- Improve staff working practices by providing a complete oversight of the whole maternity journey.

Next steps include testing to ensure that the solution functions correctly. Staff training would take place in February 2022 with an expectation that the system would go live in March 2022. It was noted that training was crucial in ensuring that the roll-out transition was smooth. A consideration had been made that training would be delivered during winter months where it was expected that there would be increased staffing pressures. This would be closely monitored. A risk regarding the capacity of the EPR team was noted and would be added to the risk register.

10. Quality Improvement Programme Update

The Trust would devise a Quality Strategy which would focus on continuous improvement.

The four key priorities identified and included as part of the Quality Account 2020/21 were:

- Improving the management of deteriorating patients
- Improving patient experience
- Continued reduction in stillbirths
- Advancing equality, diversity and inclusion

Further information was shared on the aim and objectives in place to achieve the first priority, to improve the management of deteriorating patients using the Trust's model for improvement to increase the recognition, escalation and response for adult deteriorating patients by 20% from baseline by 31 March 2022.

Endeavours would be made to increase the Trust's ability to build capacity and capability for improvement, through the utilisation of the QI methodology within Clinical Business Units. This would be measured via the online platform 'Life QI' to track progress, build skills and knowledge amongst the Trust, and provide assurance that QI methodology is leading to improvement.

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11. Estates and Facilities Quarterly Service Report

The highlights of the reports were:

- Environmental improvements had been completed including the isolation rooms within the Accident and Emergency Department to assist with infection control measures; new staff changing facilities including showers; and Ward 10, which had been used as an ICU extension during the COVID-19 pandemic, had been refurbished into a new ward which would be used flexibly based on Trust need.
- The Trust received a food hygiene visit at St Luke's Hospital and maintained its 5-star food hygiene rating. The Trust was expecting an unannounced inspection at Bradford Royal Infirmary by the end of September 2021.
- All Estates and Facilities related audits had received either significant or high assurance with a limited number of actions, all of which had since been completed.
- A new Fire Safety Manager had been appointed and there would be a new focus on risk assessments, training and infrastructure improvements.
- An Estates Strategy 'Lite' would be developed to deal with backlog-maintenance over the next three-years.

12. Getting It Right First Time (GIRFT) Update

GIRFT is a national programme designed to improve the treatment and care of patients through the in-depth review of services, benchmarking, and presenting a data driven evidence base to support change. Whilst more than 50% of the Trust's services had received a GIRFT visit; action plans had not been followed up. Steps are being taken to embed GIRFT into normal working practice, supported by senior Trust leadership and managed by a central team. The process would be clinically led and focused on quality, however, would include the involvement of whole clinical teams. To support this work a GIRFT Clinical Lead is to be appointed alongside the newly appointed Deputy General Manager. A Nursing Lead would also be identified to support this programme.

13. Quality and Patient Safety Academy Terms of Reference / Work Plan

It was agreed by the Academy that the terms of reference and work plan would be reviewed following the development session to be held by the members of the Quality and Patient Safety Academy.

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 Chair of the Academy, would like to highlight from this month's meeting:

1. Progress made on the Outstanding Maternity Services programme
2. Infection Prevention and Control Board Assurance Framework

The Academy was assured that the risks recorded on the Strategic Risk Register are appropriate in the context of the information presented, and are being managed appropriately. One new risk was noted (see below).

Matters escalated to the Board of Directors for consideration

There were no matters to escalate to the Board; however the Board is asked to note that the Quality and Patient Safety Academy terms of reference and work plan would be reviewed and

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revised following the delivery of a development session for Academy members to identify future areas of focus for the Academy.

New/emerging risks

The Academy noted an additional risk in relation to the capacity of the EPR team, which will be added to the risk register.

Recommendation

The Board is requested to note the discussions and outcomes from the Quality and Patient Safety Academy held on 29 September 2021.