

Meeting Title: Board of Directors			
Date	18.11.21	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		
Author	Jacqui Maurice, Head of Corporate Governance		
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 27 October 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 27 October 2021		
Previously approved at:	Committee/Group	Date	
	N/A		

Key Matters Discussed

The Quality and Patient Safety Academy met on 27 October. Summaries of the key items discussed at the meeting are presented below. The confirmed minutes from the meeting held in October will be available at Board in January 2022. The next meeting of the Quality and Patient Safety Academy is scheduled for 24 November.

Meeting held 27 October 2021

1. Service Presentation: Quality in Urgent and Emergency Care

The Academy held an in-depth discussion with the General Manager, Deputy Associate Director of Nursing and the Deputy Associate Director of Nursing on key challenges faced from a quality and patient safety perspective within Urgent and Emergency Care. The Academy discussed the handling of incidents and complaints and the themes presented as a result of operational pressures. The Academy welcomed the planned improvements whilst acknowledging the significant impact on staff and patients in maintaining the service. Key points drawn from the discussion were:

- Demand has increased nationally since the end of lockdown with the Trust identifying a 10 to 15% increase in patients on pre-lockdown numbers with increased attendances for paediatric patients and those in the 30 to 45 year age group further resulting in increased length of waiting time and onward flow.
- The relative performance of our BTHFT Emergency Department which is frequently listed at the top of the West Yorkshire Association of Acute Trusts (WYAAT) data and listed in the top ten Trusts nationally.
- The effects of acute staffing pressures across all areas of the Trust affecting the surge in demand and flow through the department.
- The mitigations in place to address winter pressures, the on-going Covid response and the increased stresses on staff.
- The issues experienced as a result of staffing levels and the mitigations in place to address these.

New Emergency Care Standards will be introduced nationally which involve moving away from the four hour standard and introducing a range of new standards. The Academy also noted that External services, such as GPs and the Yorkshire Ambulance Service, contribute to and affect outcomes as does the Trust's ability to discharge and move patients through the healthcare

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system.

The Academy has requested that the team present to them again, and on this next occasion provide details with regard to; how the Unit ensures lessons are being learnt rather than just documented and; provide further information on training, triage, resuscitation and paediatric induction.

2. Maternity Services Update

The Academy noted that five stillbirths were reported in September. This, in addition to the five stillbirths reported in August. All ten cases have been subject to reviews to identify any immediate learning. There have been no themes noted however all cases will be discussed in detail at the next specialty meeting. The Academy also noted that Bradford does not appear to be an outlier in month within the Local Maternity System (LMS). Regional increases in stillbirths are evident and this data will be discussed at that level. The Academy also:

- Discussed the three Significant Incidents (SIs) that were declared in September.
- Approved the 'Quarter 2 Avoiding Term Admissions into Neonatal Units (ATAIN) report' (a requirement for the Maternity Incentive Scheme).
- Noted the General Medical Council trainee survey, (a requirement of the Maternity Incentive Scheme around workforce).
- Noted the Perinatal Mortality Review Tool (PMRT) quarterly report.
- Discussed the responses to communications with women who receive a poor/negative outcome and were assured by the continued training provided to all staff and in particular telephone triage midwives. The Academy also noted the strengthening of the '72 hour response' in place with regard to poor outcomes enabling learning to reach the team in a timely manner.
- Noted the excellent assurance with regard to the provision of support to bereaved families or families with poor outcomes.
- Discussed the staffing challenges over the last few months and the mitigations in place

The Academy requested that the Head of Nursing and Midwifery provide an update in the next report on Covid vaccination rates in pregnant women and, the particular challenges in relation to SIs that involve women from ethnic minority backgrounds.

3. Magnet 4 Europe

The action plan for the four year project was discussed. The current focus is on how staff can be supported to participate in shared professional decision making, given the current operational pressures and working principles are being woven into current processes.

4. Quality Improvement (QI) Update

The key points to note with regard to the update are;

- The Live QI platform continues to manage and monitor QI across the Trust and the high level programmes of work. This has now been live for six weeks and 94 members are using the platform. The changes made to areas of work, the outcomes and impact measures are being documented and recorded.
- The priorities linked to the Trust's Quality Account were discussed and included:
 - Improving the management of deteriorating patients
 - Improving Patient Experience
 - Continued Reduction in Stillbirths
 - Advancing equality, diversity and inclusion

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- The Outstanding Theatre Service programme was launched on 13 October 2021 and the associated event was attended by more than 100 staff members. This key engagement explored issues required to create a shared vision for future theatre services. Information is being collated and clinical leads identified to lead a series of work streams. A public and patient involvement plan is also under development to support public membership of the Board.

5. Patient Safety Strategy Update

Detailed information was presented with regard to the role of the Patient Safety Specialists and the associated priorities as prescribed by NHSE/I. With regard to implementation the Academy;

- Noted that a gap analysis at BTHFT has been undertaken covering areas for improvement and priorities.
- A single Patient safety specialist post for BTHFT has been advertised.
- The Trust continues to forge links with the National Patient Safety Improvement Programmes, linking the Trust's quality priorities with the national plan.
- In due course, all staff will require training around patient safety. Training programmes are being devised nationally and plans are being developed with the BTHFT Education team for delivery.
- The Academy discussed links with the Quality Strategy and the Quality Account Improvement Priorities.

Further discussions along with a mapping exercise in relation to the quality priorities would take place at the Academy development session scheduled for 18 February 2021.

6. Patient Safety Group Highlight Report

The following key outcomes are highlighted from the discussion held:

- Focus on learning from SIs including the hospital onset Covid outbreaks and, the thematic analysis from hospital onset Covid deaths. Work is being carried out to understand the wider implications across other specialties, for example using the Electronic Patient Record (EPR) to track of referrals between specialties.
- Dissemination of information from the West Yorkshire Association of Acute Trusts (WYAAT) Shared Learning Forum.
- Feedback received from the National Patient Safety Congress regarding the management of patient safety culture, understanding the patient perspective and, creating psychological safety.
- Assurance received with regard to the harm review process for delays in diagnosis or treatment. Agreed processes within these areas are being further embedded by the Clinical Business Units (CBUs).
- Review of actions relating to a National Patient Safety Alert on the management of pleural effusion which requires modification to our current chest drain guidance.
- Electronic prescribing for discharged patients is under review by the new, recently appointed, Medicines Safety Officer.
- Concerns around harm for those patients waiting for reviews and the pressures to address and reduce waiters. The Academy noted the work underway within the Performance team to identify high risk pathways.

7. Clinical Outcomes Group Highlight Report

The Academy was asked to note that progress had been limited over the last 12 to 14 months due to the reframing of the Trust's clinical priorities however there are a number of positives to report

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with regard to learning, improvement and assurance.

- Reviews had taken place with regard to governance and reporting structures including the review of subgroup terms of reference.
- Getting It Right First Time (GIRFT) group was now established with a role to reduce variation in clinical outcomes and improve patient care. The priority areas identified include gastroenterology and neurology.
- Programmes of work underway included;
 - High Priority Audit Programme – Supporting specialities to focus on priority audits and improvements in patient care.
 - National Institute for Health and Clinical Excellence (NICE) guidance compliance.
 - New services/procedures.
 - Policies.
 - Local Clinical Audits.
 - Reports from sub-groups.
 - The restart of Clinical Governance processes across the CBUs.
- The Quarter 3 plan was noted which included:
 - Support for the National Clinical Audit Programme.
 - Re-establishment of links with CBUs and specialty services.
 - Celebration of excellence and sharing learning.
 - Exploration of other platforms to share learning with other partners and organisations.

The Clinical Outcome group is a key part of the structure in terms of patient safety and quality.

8. Patient Experience Group Highlight Report including Complaints and Parliamentary Health Service Ombudsman (PHSO) Report

The Academy received a comprehensive update on the areas of learning, improvement and assurance on Q1 and Q2 regarding the work of the Patient Experience Group which includes within its remit complaints and PHSO cases. The following key points were noted.

- Patient experience shared within peer groups and at regional level in order to develop and improve services in the Trust.
- Friends and Family feedback is currently being analysed.
- Feedback noted from the National Care Quality Commission (CQC) surveys.
- Deep dives carried out based on complaint themes.
- Services/guidelines and Standard Operating Procedures created where required
- On the recommendation of Healthwatch, the Patient Experience team is evidencing learning from complaints and in collaboration with communications.
- Collaborative pieces of work are underway, e.g. carers' passport developed and launched in September.
- The development of the relatives' line which is now a permanent Trust feature and plans for its expansion.

With regard to complaints; weekly complaints meetings held for management oversight regarding lessons to be learned, with challenge to the CBU leads. All complaints related work is considered by the Risk team. Key Performance Indicators for response times are monitored against the Complaint Policy and national guidance. Ten complaints are currently open with the PHSO where local resolution has failed. The Trust has provided a financial remedy following liaison with the patient/family of six cases, however, the final outcomes are awaited. The remainder are delayed due to the office of the Complaints Ombudsman. High Assurance was received from an internal audit in March 2021 on the handling of Concerns and Complaints.

Whilst a lot of good work is taking place the Academy noted that the results from the recently

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published in-patient survey are extremely disappointing. The survey was undertaken in Autumn 2020 when the Trust (and the region) was in the midst of the second Covid peak. A report on the results from the survey will be provided to the Academy in November and to the Board of Directors.

9. Infection Prevention and Control (IPC) Board Assurance Framework

The following key points are highlighted from the discussion of the Q2 IPC report.

- An oversight of hospital acquired infections showed some infection areas benchmarking equal to or better than the national average however, the Trust is an outlier nationally for MRSA blood stream infections.
- Deep dives have been undertaken, with improvements and learning shared. A thematic analysis of MRSA had been undertaken and the learning from four cases shared in detail with the Academy.
- Speeding up of MRSA reporting processes with laboratory managers is under discussion.
- Improvement work continues based on the lessons learned and these were described in detail with learning included from 2020/21. Further, the learning and improvement programmes have been shared with both Care Quality Commission (CQC) and NHS England colleagues. Advice has been received and action plans reviewed. The programme is monitored through the IPC Committee.
- All MRSA bacteraemia cases are reported through the clinical incident reporting system to support a robust partnership between infection control and the governance and risk teams.
- Multi-professional post-infection weekly review meetings are held and action plans agreed. Once embedded these plans continue to be monitored through the IPC Committee.
- Clostridium Difficile and E Coli infections remain below other regional Trust rates of infection and benchmark within national contract set objectives.

10. Quality Oversight and Assurance Profile

The key points from the discussion focussed on:

- A number of significant events concerning patients presenting with abnormal Neurology to the Emergency Department have been identified with learning shared both internally and across the organisation.
- A Healthcare Safety Investigations Branch National Learning report received has been cascaded across the organisation consisting of a thematic analysis of 22 national investigations and three safety themes.
- Videos are being developed with the Education team and the Electronic Patient Record to both aid staff at the point of care and to act as a refresher. A library of these will be available for all staff via Trust computers.
- Themes have been identified around Yorkshire Ambulance Service inter-facility transfers and a review will be undertaken. Monitoring is underway on a daily basis through the safety huddles and through the Safety Event group.

11. Serious Incident (SIs) Report

In the last reporting period there were two SIs declared between 13 September and 17 October 2021:

- SI 2021/19345 related to sub-optimal care of the deteriorating patient meeting SI criteria. The patient was reported to be recovering with immediate learning around communications noted. The investigation is underway.
- SI 2021/19878 concerned a diagnostic incident and failure to act on test results. A review of previously introduced systems and processes will be investigated to understand system

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failure.

In accordance with the requirements of the Healthcare Safety Investigation Branch (HSIB); a maternity related incident was reported via STEIS, SI 2021/19879. An independent investigation will be carried out by HSIB.

One SI has been concluded since the last report:

- SI 2021/15080 Never Event: Transfusion or transplantation of ABO-incompatible blood components or organs.
- There have been no Never Events declared since the last report or since July 2021, or breaches in Duty of Candour since the last report and since August 2016.
- Eight SI investigations are currently ongoing in the organisation.
- A 2021 Getting It Right First Time (GIRFT) data pack which benchmarks litigation and activity spends per specialty at national level has been compiled and is being reviewed prior to distribution. This will link to the wider GIRFT improvement work.
- An internal audit of patient safety governance processes was commenced in October 2021 by Audit Yorkshire.
- Four Central Alerting System (CAS) alerts were received in September of which only one required a response and which is now complete.
- There were five external reportable safety events during September.
- A monthly Care Quality Commission engagement meeting was held in September.

The Academy was assured the Trust has processes in place to identify, investigate, improve and learn from SIs.

12. Strategic Risks relevant to the Academy

The Academy noted that no new risks have been added to the Risk Register for the Academy. That Four risks require a review and, that all risks have appropriate mitigation in place. Three risks were highlighted in particular:

- Risk 3104. The second of four telephony migrations has been completed successfully.
- Risk 3585. A System Quality summit has been commissioned by the System Quality Committee and will be led by the Chief Nursing Officer for Airedale, following concerns raised about the increasing numbers of patients presenting with mental health and wellbeing needs. This includes how Children and Young People admitted with mental health needs are managed, particularly around physical and chemical restraint. Mitigations are in place and work continues to ensure safe processes for these patients.
- Risk 3357 regarding theatre ventilation remains open. Significant work is underway throughout all theatres. This is a long-term project.

The Academy was assured that the risks continue to be appropriately managed.

13. Quality and Patient Safety Academy Dashboard

The dashboard remains under review. A number of areas have already been discussed under distinct items. The Academy noted the following;

- Crude Mortality information is to be removed, however, Hospital Standardised Mortality Ratio (HMSR) and Summary Hospital-level Mortality Indicator (SHMI) will remain and the updated graphs were noted. A refresher session for the Board was suggested.
- Category 3 pressure ulcers have taken a downturn
- There are increasing numbers of patients on ventilation and non-invasive ventilation.
- Falls with harm continue to reduce.

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- The staffing challenges were recognised and it was noted that these were discussed at the People Academy. The earlier presentation from the Urgent and Emergency Care team also highlighted the issues they were experiencing. Mitigations are however in place.

14. Safeguarding Children Quarterly Report

A comprehensive report was received. The key points were highlighted around learning, improvement and assurance.

- Training compliance has improved for Safeguarding Children over all levels despite the pressures of Covid over the last twelve months.
- Additional expert Child Exploitation (CE) training has been provided following the release of the Thematic Child Sexual Exploitation (CSE) review.
- The team is now proactive in commencing additional training and other actions prior to reports/action plans/recommendations being published.
- Adults and Children Safeguarding team contributed to safeguarding week; the theme of which was domestic abuse.
- The main challenge is in relation to the Mental Health Crisis pathway for children and young people.
- There are challenges with regard to the Crisis pathway introduced in April 2021 for children and young people being cared for on the ward. The development of the multi-agency crisis pathway is assisting the Trust to move towards a better position for the young people in terms of escalation processes to find the right placement for these children.
- Behavioural issues continue to remain a challenge, however, a Policy is being written for the Management of Distressed, Aggressive and Violent paediatric patients considering de-escalation techniques, the use of the Mental Health Act and legal support.
- Voluntary services are working daily in the Trust as part of a new twelve month pilot in the Emergency Department looking at violence reduction.
- The Royal College of Paediatrics and Child Health National Standards for child protection medicals / safeguarding medical guidance were issued earlier in the year. The Trust has its own action plan and an audit is in train with most areas currently identified as 'green'.
- The Trust produces action plans for every child safeguarding practice review. The Named Professionals actively review all practice review action plans going back 8-10 years on a regular basis to ensure learning remains embedded.
- In particular the Academy noted that one of the main national challenges is children and young people in mental health crisis, particularly as this area of work has proved more significant as Covid numbers increased and this continues to be an issue. Support from the Trust will be essential in elevating these cases with legal support when required
- An internal audit undertaken in summer 2021 looking at children's safeguarding in the Trust has been completed and high assurance was received.

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, I would like to highlight from this month's meeting:

1. Urgent and Emergency Care Progress
2. The Infection Prevention and Control Board Assurance Framework
3. The Safeguarding Children Quarterly Report

The Academy is assured that the risks recorded on the Strategic Risk Register are appropriate in the context of the information presented, and are being managed appropriately.

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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 the five still births recorded in September and, whilst BTHFT does not appear to be an outlier, the regional review being undertaken given the regional increases in stillbirths.

The Board is further asked to note that the in-patient survey results have now been published and are disappointing. The report presented from the Patient Experience Team at item reflects a lot of the positive work that is now underway as part of our restart - it is expected that this will impact the results of our subsequent surveys in a more positive way.

New/emerging risks

There were no new risks.

Recommendation

The Board is requested to note the discussions and outcomes from the Quality and Patient Safety Academy held on 27 October 2021.