


# QUALITY AND PATIENT SAFETY (QPS) ACADEMY MINUTES

<b>Date:</b>	27 October 2021	<b>Time:</b>	14:00-17:00
<b>Venue:</b>	Microsoft Teams meeting	<b>Chair:</b>	Mr Mohammed Hussain (MH), Non-Executive Director
<b>Present:</b>	<p><b>Non-Executive Directors:</b></p> <ul style="list-style-type: none"> <li>- Mr Mohammed Hussain (MH), Non-Executive Director/Chair</li> <li>- Professor Janet Hirst (JHi), Non-Executive Director</li> <li>- Mr Jon Prashar (JP), Non-Executive Director</li> </ul> <p><b>Executive Directors:</b></p> <ul style="list-style-type: none"> <li>- Dr Ray Smith (RS), Chief Medical Officer</li> <li>- Ms Karen Dawber (KD), Chief Nurse</li> <li>- Dr Paul Rice (PR), Chief Digital and Information Officer</li> </ul>		
<b>Attendees:</b>	<ul style="list-style-type: none"> <li>- Dr LeeAnne Elliott (LAE), Deputy Chief Medical Officer</li> <li>- Dr Paul Southern (PSo), Consultant Hepatologist/Associate Medical Director</li> <li>- Dr Robert Halstead (RH), Consultant in Emergency Medicine/Associate Medical Director</li> <li>- Dr Michael McCooe (MM), Consultant in Anaesthesia/Associate Medical Director</li> <li>- Dr Padma Munjuluri (PM), Consultant Obstetrician and Gynaecologist/Associate Medical Director</li> <li>- Mrs Sally Scales (SS), Director of Nursing</li> <li>- Mrs Karen Bentley (KB), Assistant Chief Nurse</li> <li>- Ms Adrienne Lake (AL), Assistant Director of Finance</li> <li>- Ms Judith Connor (JC), Associate Director of Quality</li> <li>- Mrs Su Coultas (SC), General Manager, Chief Medical Officer's Office</li> <li>- Ms Liz Tomlin (LT), Head of Quality Improvement and Clinical Outcomes</li> <li>- Mrs Adele Hartley-Spencer (AHS), Associate Director of Nursing</li> <li>- Mrs Sara Hollins (SH), Head of Nursing, Midwifery</li> <li>- Mrs Kay Rushforth (KR), Head of Nursing, Children's Services</li> <li>- Mrs Claire Chadwick (CC), Nurse Consultant/Director of Infection, Prevention and Control</li> <li>- Ms Jane Kingsley (JK), Lead Allied Health Professional</li> <li>- Dr Mark Kon (MK), Consultant/Clinical Director, Radiology</li> </ul>		
<b>In Attendance</b>	<ul style="list-style-type: none"> <li>- Mr Edward Cornick (ET), General Manager, Emergency Department, Lizzi Vooght (LV), Deputy Associate Director of Nursing, Unplanned Care, and Joanna Stedman (JS), Deputy Associate Director of Nursing, Unplanned Care, in attendance for agenda item QA.10.21.5.</li> <li>- Dr Jo Sims (JS), Consultant Paediatrician, in attendance for agenda item QA.10.21.18.</li> <li>- Ms Faye Alexander (FA), Education Manager, representing Amanda Hudson.</li> <li>- Ms Laura Parsons (LP), Associate Director of Corporate Governance/Board Secretary</li> <li>- Ms Jacqui Maurice (JM), Head of Corporate Governance</li> <li>- Ms J Kitching, Minute-taker</li> </ul>		




<b>Observers</b>	<ul style="list-style-type: none"> <li>- Mr Barrie Senior, Non-Executive Director</li> <li>- Mrs Michelle Turner, Strategic Director of Quality and Nursing</li> <li>- Ms Elizabeth Brooks, Risk and Governance Manager</li> </ul>
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<b>Agenda Ref</b>	<b>Agenda Item</b>	<b>Actions</b>
<b>QA.10.21.1</b>	<b>Apologies for Absence</b>	
	<ul style="list-style-type: none"> <li>- Mr John Bolton (JB), Deputy Chief Medical Officer/Operations Medical Director</li> <li>- Ms Rachael Waddington (RW), Deputy Director of Operations</li> <li>- Ms Jemma Tesseyman (JT), Named Nurse for Safeguarding Children</li> <li>- Ms Amanda Hudson (AH), Head of Education</li> <li>- Mrs Joanne Hilton (JH), Assistant Chief Nurse</li> <li>- Mrs Sarah Freeman (SF), Associate Director of Nursing</li> <li>- Ms Victoria Egan (VE), Clinical Risk Manager</li> <li>- Mr Kevin Mercer (KM), Consultant/Clinical Director, Vascular/Urology</li> <li>- Dr Rishi Khanna (RK), Consultant/Clinical Director, Anaesthetics and Critical Care</li> <li>- Dr Carolyn Robertson (CR), Consultant/Clinical Director, Obstetrics and Gynaecology</li> <li>- Ms Melanie Johnson (MJ), Patient Safety Collaborative Programme Manager</li> <li>- Mr Altaf Sadique (AS), Non-Executive Director</li> <li>- Mrs Sarah Turner (ST), Assistant Chief Nurse, Safeguarding</li> </ul>	
<b>QA.10.21.2</b>	<b>Declarations of Interest</b>	
	There were no declarations of interest.	
<b>QA.10.21.3</b>	<b>Minutes of the meeting held on 29 September 2021</b>	
	<p>The minutes of the meeting held on 29 September 2021 were approved.</p> <p>The Academy noted that the following actions had been concluded:  QA21034 – QA.5.21.8 – Update from the Haemoglobinopathy Team – Update on Speciality Deep Dives.  QA21036 – QA.5.21.16 – Patient Safety Specialist Update.  QA21042 – QA.6.21.5 – Service Presentation – Infection Prevention and control with focus on Sepsis.  QA21059 – QA.9.21.13 – Quality Improvement Programme Update.  QA21062 – QA.9.21.5.2 – Quality Oversight and Assurance Profile.  QA21063 – QA.9.21.5.4 – Strategic Risks relevant to the Academy.  QA21064 – QA.9.21.8 – Patient Safety Group.  QA21065 – QA.9.21.9 – Infection Prevention and Control Board Assurance Framework.  QA21067 – QA.9.21.16 – Quality Academy Terms of Reference.</p>	
<b>QA.10.21.4</b>	<b>Matters Arising</b>	
	There were no matters arising from the Minutes that were not already on the agenda. Verbal updates were given at the meeting on the outstanding and closed actions and these were reflected in	


	the action log.	
QA.10.21.5	<b>Service Presentation – Quality in Urgent and Emergency Care</b>	
	 <p>QA.10.21.5 - Quality in Urgent and Emergency Care</p> <p>EC, JS and LV were welcomed to the meeting to present an update from the Emergency Department (ED) on some of the challenges faced from a quality and patient safety perspective, detailing the assurance in place and the planned improvements in response to these challenges, with incidents, complaints and themes highlighted as a result of operational pressures. An in depth discussion was held and the key points noted:</p> <ul style="list-style-type: none"> <li>• ED demand has increased massively nationally since the end of lockdown with the Trust identifying a 10 to 15% increase in patients on pre-lockdown numbers. Increased attendances have been noted for paediatric patients and those in the 30 to 45 year age group resulting in an increased length of waiting time and onward flow.</li> <li>• The Bradford Teaching Hospital NHS Foundation Trust's ED data is frequently listed at the top of West Yorkshire Association of Acute Trust (WYAAT) data and listed in the top ten Trusts nationally.</li> <li>• Acute staffing pressures were noted across all areas of the Trust include the ED, particularly nursing staff and middle grade doctor rotas. Nursing and medical staff pressures have a direct impact on the ED when trying to manage the surge in demands and flow through the department. Risk assessments are completed given the staffing and demand pressures and improvement work is underway in the Department in response to the challenges noted as business continues.</li> <li>• New Emergency Care Standards are being introduced nationally with the implementation date to be confirmed. These involve moving away from the four hour standard into a whole range of new standards. Detailed action plans are being created from the initial risk assessment. The standards will address previously highlighted concerns to support quality and patient safety issues.</li> <li>• External services, for example General Practice (GP) and the Yorkshire Ambulance Service, contribute to and affect outcomes as does the Trust's ability to discharge and move patients through the healthcare system.</li> <li>• Pressures resulting from staffing levels and the gaps in skills between experienced nurses and newly qualified nurses.</li> <li>• Delays in triage and specialty in reach, for example mental health/vulnerable patients.</li> <li>• Complaint numbers have increased over the last few months as a consequence of the high numbers of attendances and common themes.</li> <li>• The recruitment programme is progressing well including the recruitment of a cohort of Advanced Care Practitioners to assist with middle grade stability. Physician Associates are a longer</li> </ul>	


	<p>term project but posts are being worked up. Permanent resource for resilience with middle grade pressures are under consideration.</p> <ul style="list-style-type: none"> <li>• External training is being considered from the Faculty of Emergency Nursing.</li> <li>• All lessons learned from complaints are shared both locally and with the wider team and learning is disseminated through governance streams. Direct training sessions are held where appropriate.</li> <li>• Work is underway at system level to develop and create a closed ED model for walking patients and a separate area for higher acuity patients.</li> <li>• Working with the Clinical Commissioning Group (CCG) across the urgent and emergency local care system including GP colleagues in an attempt to help address the health needs of the local population.</li> <li>• Operational level system meetings to be introduced over the winter period.</li> <li>• Plans in place to mitigate for winter pressures, ongoing Covid and increased fatigue of staff. Strategies to be introduced to enable integrated working with Allied Health Professionals.</li> <li>• The Yorkshire Contributory Factors framework and the after action review has been undertaken.</li> </ul> <p>RS thanked EC, LV and JS and their teams for all their work over these unprecedented times noting the significant impacts on staff and patient facilities whilst maintaining the emergency care.</p> <p>LAE noted the importance of learning focussing on all the positive results as an encouragement for staff.</p> <p>PR agreed to meet with LV outside of the meeting to discuss the digital initiatives being worked around place relating to the urgent/emergency care environment.</p> <p>KD noted the fantastic work around patient safety underway in the department and requested the Academy were informed of the top three risks and how these were measured, monitored and escalated. Violence and aggression issues linked to the safety of patients, safety of staff and the care of the vulnerable client are of paramount importance and the mitigation in place was discussed by LV, for example CCTV, panic alarms and support provided to staff, for example human factors training and conflict resolution.</p> <p>MH thanked EC, LV and JS for their contributions and RS, KD and JC agreed that the following would be picked up in a future Executive to Clinical Business Unit meeting:</p> <ul style="list-style-type: none"> <li>• The top three risks.</li> <li>• How the Unit ensures lessons are being learned.</li> <li>• Training programmes.</li> <li>• Triage, resuscitation and paediatric induction.</li> </ul>	<p>QA21069 Chief Medical Officer/ Chief Nurse/ Associate Director of Quality RS/KD/JC</p>
<b>QA.10.21.6</b>	<b>Maternity Services Update</b>	
	The paper and appendices were taken as read and SH highlighted	

	<p>the key points:</p> <ul style="list-style-type: none"> <li>• Monthly stillbirth position – Five cases were reported in September and as noted last month, five cases were reported in August. Both sets of five cases have undergone a review to identify the immediate learning. No themes have been noted, however, all cases will be discussed in detail at the next specialty meeting.</li> <li>• Bradford does not appear to be an outlier in month within the Local Maternity System (LMS) and regional increases in stillbirths are evident. Data will be discussed regionally.</li> <li>• The three SIs declared in September were discussed.</li> <li>• The Academy approved Appendix 1, the Quarter 2 Avoiding Term Admissions into Neonatal Units (ATAIN) report, a requirement for the Maternity Incentive Scheme. The positive report has been shared at the last safety meeting with the Board Level Safety Champions. Out of 43 admissions in the last quarter only one case was agreed as an avoidable admission due to poor application of a local guideline.</li> <li>• The Academy noted the General Medical Council trainee survey (Appendix 2), a requirement of the Maternity Incentive Scheme around workforce. The service achieved 87% of the criteria within the acceptable threshold. The areas for improvement required have already been considered, for example around workforce. SH anticipated the next survey should see improved results.</li> <li>• The Academy noted Appendix 5, the Perinatal Mortality Review Tool (PMRT), quarterly report, reported on a three monthly basis. There have been some changes to the timings of PMRT reporting and the monitoring of baby deaths. The original target was missed for two babies by two days due to pressures in Maternity however, Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the United Kingdom (MBRACE-UK), who validate the data have accepted the delay on this occasion. An automatic system is now in place which triggers babies final review dates.</li> <li>• Staffing challenges over the last few months.</li> <li>• Excellent assurance providing support to bereaved families or families with poor outcomes.</li> </ul> <p>JP, Non-Executive Director Champion for Maternity, provided assurance to the Academy, on behalf of the People Academy, of the accuracy of the report and the addressing of all challenges.</p> <p>JHi queried the level of assurance with regards communication in general with women who receive a poor/negative outcome. SH noted the Maternity Voices Partnership is the main forum for ensuring the voices of women are heard. SH discussed the good relationships and close working ensuring messages are pitched at the appropriate level to patients and that these are understood. Telephone messages are often an area for complaints, however, training is provided to all staff and in particular to telephone triage midwives.</p> <p>KD provided full support to SH's response noting the Trust does not always see an element of poor communication in relation to poor</p>	
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	<p>outcomes. Robust reviews of any poor outcome is held within 72 hours enabling learning to reach the team in a timely manner and processes have been strengthened over the last few months. The 72 hour review for PMRT now enables review within a timely manner.</p> <p>SH agreed to provide an update in the next report on:</p> <ul style="list-style-type: none"> <li>• Vaccination rates in pregnant women.</li> <li>• The challenges around Serious Incidents (SI) in relation to Black and Mixed Ethnicity (BAME) patients.</li> </ul> <p>The paper was noted by the Academy.</p> <p><b>Decisions:</b>  Quarter 2 ATAIN report – Approved.  General Medical Council trainee survey – Noted.  Perinatal Mortality Review Tool - Quarterly report – Noted.</p>	QA21070 Director of Midwifery SH
<b>QA.10.21.7</b>	<b>Safeguarding Adults and Children – Update on mental health, risks and impact on organisation</b>	
	This item was deferred to the November meeting.	
<b>QA.10.21.8</b>	<b>Magnet4Europe</b>	
	<div>   </div> <p>QA.10.21.8 - Timeline.Magnet4Europe.pptx</p> <p>The above presentation was delivered by SS, providing an update on this research study noting the Magnet4Europe aims and principles. SS discussed the action plan of this four year project, which commenced in March 2020, the key areas of focus and the current challenges.</p> <p>The principle of the Magnet approach is about engaging clinical staff in decision-making. Consideration is being given as to how staff can be supported to participate in shared professional decision making, given the current operational pressures. A key focus is to progress working principles into current processes.</p> <p>The report was noted by the Academy and MH requested sight of the project timeline.  <b>Post-meeting noted</b> – Project timeline slide added above.</p>	QA21071 Director of Nursing SS
<b>QA.10.21.9</b>	<b>Quality Improvement (QI) Update</b>	
	<div>  </div> <p>QA.10.21.9 - Quality Improvement Update</p> <p>LT presented an update on Quality Improvement (QI) and the following were noted:</p> <ul style="list-style-type: none"> <li>• The Live QI platform continues to manage and monitor QI</li> </ul>	




	<p>across the Trust and the high level programmes of work. This has been live for six weeks and 94 members are using the platform. The changes made to areas of work, the outcomes and impact measures will be documented and recorded.</p> <ul style="list-style-type: none"> <li>The priorities linked to the Quality Account were discussed: <ul style="list-style-type: none"> <li>Improving the management of deteriorating patients - This topic continues to be managed by the Managing the Deteriorating Patient Working Group (which includes Sepsis), to improve the recognition, escalation and response of adult patients deteriorating, along with the implementation of the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) documentation. Learning, improvement and assurance were noted.</li> <li>Improving Patient Experience.</li> <li>Continued Reduction in Stillbirths.</li> <li>Advancing equality, diversity and inclusion.</li> </ul> </li> <li>The Outstanding Theatre Service programme was launched on 13 October 2021. A fantastic event was attended by over one hundred members of staff. This engagement exercise explored issues required to create a shared vision for future theatre services. Information is being collated and clinical leads are being identified to lead the workstreams. A public and patient involvement engagement plan is being developed to enable a member of the public to join the Board as the programme develops.</li> <li>Capacity and capability building was noted as a key objective for the QI team. Individual projects will identify the areas of impact.</li> </ul> <p>The presentation was noted and LT thanked.</p>	
<b>QA.10.21.10</b>	<b>Patient Safety Strategy Update</b>	
	 <p>QA.10.21.10 - Patient Safety Specia</p> <p>LAE presented the report on behalf of the Patient Safety Specialists around the priorities provided to the Trust by NHS England.</p> <p>LAE described the requirement for an embedded patient safety culture and system providing continuously improving patient safety. The framework on which the National Patient Safety Strategy is set was discussed. A gap analysis on Trust priorities for the patient safety specialist role has been undertaken. The areas of improvement and priorities to date were discussed, the work in progress and the planning required to take the agenda forward. A single Patient Safety Specialist post for BTHFT has just been advertised.</p> <p>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</p>	

	<p>around patient safety and training programmes are being devised nationally and plans developed to identify how training is managed, with the Education team and subsequently rolled out to staff. It is envisaged all training will be on line and recorded through Electronic Staff Record (ESR) mandatory training records, with different levels of staff accessing different levels of training. LAE envisaged an update would be available in three months.</p> <p>Discussion ensued around areas of focus and how these may be linked to the Quality Strategy and the quality priorities linked to the Quality Account.</p> <p>JC noted the focus on the national priorities and the progress made in these areas by the Trust.</p> <p>The Academy noted the report and agreed to further discussions and a mapping exercise around the quality priorities at the development session on 18 February 2022.</p>	<p>QA21072 Deputy Chief Medical Officer/ Associate Director of Quality LAE/JC</p> <p>QA21073 Associate Director of Quality JC</p>
<b>QA.10.21.11</b>	<b>Patient Safety Group Highlight Report</b>	
	 <p>QA.10.21.11 - Patient Safety Group</p> <p>LAE discussed the Patient Safety Group Highlight report for October 2021.</p> <ul style="list-style-type: none"> <li>• Focused discussions were held on improvement, learning and assurance in line with the ethos of the Academy regarding learning from SIs including the hospital onset Covid outbreaks and the thematic analysis from hospital onset Covid deaths. Following the sharing of this information, work is being carried out to understand the wider implications across other specialties, for example the Electronic Patient Record (EPR) and robust systems for the tracking of referrals between specialties.</li> <li>• JC and LAE share learning with the WYAAT Shared Learning Forum.</li> <li>• Feedback has been received from the National Patient Safety Congress regarding the management of patient safety culture, understanding the patient perspective and in relation to creating psychological safety.</li> <li>• Assurance received at the meeting concerned 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).</li> <li>• Reviewed actions relating to a National Patient Safety Alert on the management of pleural effusion which requires modification to current chest drain guidance is being actioned by the respiratory team.</li> <li>• Electronic prescribing for discharged patients was noted to be under review by the new Medicines Safety Officer, recently appointed. This post reports to the Medicine Safety Group.</li> </ul>	





	<p>RS noted concerns around harm for those patients waiting for reviews and the pressures to address and reduce waiters, with current challenges faced by the clinical teams.</p> <p>JC noted Carl Stephenson, Associate Director of Performance, is devising a pathway at Trust level, working with governance leads in both Care groups in an attempt to identify high risk pathways. Discussions continue at the Patient Safety group regarding timelines.</p> <p>The report was noted by the Academy.</p>	
<b>QA.10.21.12</b>	<b>Clinical Outcomes Group Highlight Report</b>	
	 <p>QA.10.21.12 - Clinical Outcomes Gro</p> <p>PM, Associate Medical Director for Clinical Outcomes, was welcomed to the Academy by MH. PM presented the Clinical Outcomes group highlight report noting progress made over the last 12 to 14 months has been limited due to the Trust's clinical priorities. The learning, improvement and assurance key highlights were discussed.</p> <ul style="list-style-type: none"> <li>• Terms of Reference, governance and reporting structure reviews including review of Terms of Reference of subgroups.</li> <li>• Getting It Right First Time (GIRFT) group now established to reduce variation in clinical outcomes and improve patient care. Twenty-eight visits have taken place focusing on three priority areas including gastroenterology and neurology.</li> <li>• Programmes of work described including: <ul style="list-style-type: none"> <li>• High Priority Audit Programme – Supporting specialities to focus on priority audits and improvements in patient care.</li> <li>• National Institute for Health and Clinical Excellence (NICE) guidance compliance.</li> <li>• New services/procedures.</li> <li>• Policies.</li> <li>• Local Clinical Audits.</li> <li>• Reports from sub-groups.</li> <li>• Clinical Governance processes restarted across the CBUs.</li> </ul> </li> </ul> <p>The Quarter 3 plan was noted:</p> <ul style="list-style-type: none"> <li>• To support the National Clinical Audit Programme.</li> <li>• To re-establish links with CBUs and specialty services.</li> <li>• To celebrate excellence and share learning.</li> <li>• To explore other platforms to share learning with other partners and organisations.</li> </ul> <p>RS thanked PM and welcomed her to the Academy, noting the Clinical Outcome group is a key part of the structure in terms of patient safety and quality.</p> <p>The report was noted by the Academy.</p>	

QA.10.21.13	<b>Patient Experience Group Highlight Report including Complaints and Parliamentary Health Service Ombudsman (PHSO) Report</b>	
	<div data-bbox="424 338 488 405" data-label="Image"> </div> <p data-bbox="352 405 560 456">QA.10.21.13 - Patient Experience Gi</p> <p data-bbox="352 506 1225 607">KB provided an update on the areas of learning, improvement and assurance, of Quarters 1 and 2 from the Patient Experience Group which incorporates complaints and PHSO cases.</p> <p data-bbox="352 633 724 667">KB highlighted the following:</p> <ul data-bbox="352 667 1241 2040" style="list-style-type: none"> <li>• Patient experience is being shared within peer groups and at regional level in order to develop and improve services in the Trust.</li> <li>• Friends and Family feedback is currently being analysed.</li> <li>• Feedback noted from the National Care Quality Commission (CQC) surveys.</li> <li>• Deep dives are carried out around complaint themes.</li> <li>• Services/guidelines and Standard Operating Procedures created.</li> <li>• Development of apps to support chaplaincy SPaRC model.</li> <li>• Embedding kindness continues to be developed and promoted throughout the Trust.</li> <li>• On the recommendation of Healthwatch, Patient Experience is looking at client transparency evidencing learning from complaints and in collaboration with communications.</li> <li>• Constant benchmarking with peers on collaborative pieces of work, eg carers' passport developed and launched in September.</li> <li>• Patient Safety Partner development work to meet the national framework.</li> <li>• Regular presentations on areas of responsibility to Trust Committees.</li> <li>• Weekly complaint meetings held for management oversight regarding lessons to be learned, with challenge to the CBU leads. KB and her team revisit actions from previous complaints testing staff awareness and the introduced processes remain in place. Actions are, therefore, revisited to ensure learning has been embedded. All complaint work is considered by the Risk team with records viewed and concerns identified. KD provided assurance to the Academy.</li> <li>• Key Performance Indicators for response times monitored against the Complaint Policy and national guidance.</li> <li>• Ten complaints are currently open with the Parliamentary Health Service Ombudsman where local resolution has failed. The Trust has provided a financial remedy following liaison with the patient/family, for a recent case. Final outcomes of six cases are awaited. The remainder are delayed due to the office of the Complaints Ombudsman.</li> <li>• High level of assurance received from an external audit in March 2021, by Audit Yorkshire on Concerns and Complaints</li> </ul>	


	<p>Review.</p> <ul style="list-style-type: none"> <li>Participation in the monthly CQC meeting providing a high level of assurance.</li> </ul> <p>MH thanked KB for the comprehensive update.</p> <p>LAE noted the Patient Safety Specialists are currently considering Patient Safety Partners as part of the Patient Safety Strategy. The Partners will work directly with the Patient Safety Specialists regarding issues of quality and safety with the recruitment, training and monitoring of individuals being key. The Patient Safety Partners will be independent patient experts who will provide an opinion on the management of safety across the organisation and will be a paid individual. JC is currently undertaking work across place from a system perspective around funding.</p> <p>KD noted the disappointing results from the recently published In-patient Survey. Further details will be provided however KD noted the survey was undertaken in Autumn 2020 when the Trust and the region recorded the second Covid peak. Unfortunately the measures put in place since the survey will not illustrate the difference. Further details will be provided at the November 2021 QPS Academy.</p> <p>LT noted learning and learning systems are being developed by the organisation. Learning continues to be shared and embedded through the continuous improvement strategy the QI team are working towards. LAE raised the learning and information systems used to embed data throughout the Trust noting this is not an easy exercise but systems are being developed in order a process can be achieved.</p> <p>MH noted the amazing work around the relatives' line which is now a permanent Trust feature. KB highlighted the plans being devised for the expansion of the relatives' line around for example contacting patients with recent simple discharges for any follow-up questions.</p> <p>The Academy noted the presentation.</p>	<p>QA21074 Assistant Chief Nurse KB</p>
<b>QA.10.21.14</b>	<b>Infection Prevention and Control (IPC) Report – Quarter 2</b>	
	 <p>QA.10.21.14 - Quarter 2 - Infection</p> <p>CC discussed the Quarter 2 IPC report focusing on learning, the development of improvement strategies in IPC and the assurance, noting the key highlights.</p> <ul style="list-style-type: none"> <li>An oversight of hospital acquired infections was presented with some infection areas benchmarking equal to or better than the national average, for example Clostridium Difficile and E Coli, with cases seen in 2020 remaining similar throughout 2021. However, the Trust is an outlier nationally for MRSA blood stream infections.</li> <li>Deep dives have been undertaken, with improvements and learning shared. A thematic analysis of MRSA had been</li> </ul>	

	<p>undertaken and the learning from four cases was described noting the themes and the close working between areas within the Trust, for example within the Intensive Care Unit.</p> <ul style="list-style-type: none"> <li>• All learning from these complex cases has been discussed on the wards with all relevant clinical teams, by the IPC team and practice based educators.</li> <li>• The speeding up of the MRSA reporting process with laboratory managers is under discussion.</li> <li>• Topical decolonisation treatment has now commenced which reduces the risk of any blood stream infections. A topical body wash QI programme for vascular patients has been implemented and this is now being extended for all acute inpatient admissions for the first five days of admission.</li> <li>• Comparison with 2020/21 cases related to skin and soft tissue especially in vascular patients have not been identified to be related to 2021/22 themes. Improvement work continues based on the lessons learned and these were described in detail with learning included from 2020/21.</li> <li>• The learning and improvement programmes have been shared with both the Care Quality Commission (CQC) and NHS England colleagues. Advice has been received and action plans reviewed. The programme is monitored through the IPC Committee.</li> <li>• 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.</li> <li>• 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.</li> <li>• Clostridium Difficile and E Coli infections remain below other regional Trust rates of infection and benchmark within national contract set objectives.</li> </ul> <p>MH thanked CC for the presentation of the learning journey and the report was noted.</p> <p>JHi queried whether aseptic technique training for pre-registration staff was provided at induction. CC noted that medical students and student nurses have training and practical assessments in aseptic no touch techniques and with regards the rotation, there plans are to ensure there are no lapses in learning.</p> <p>LAE noted capacity and capability QI training will be difficult to measure but the work undertaken by CC and team is amazing as they fully understand the tools and techniques required to roll this out throughout the organisation.</p> <p>MH suggested this study be shared with other Academies and the Board of Directors.</p> <p>MH queried Ward 24 and the need to look at plans to minimise contact between in-patients and day attenders. CC noted an update on Covid is provided in the Board Assurance Framework (BAF) on a monthly basis and this issue is currently being overseen by the General Managers.</p>	<p>QA21075 Associate Director of Corporate Governance LP</p>
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<b>QA.10.21.15</b>	<b>Digital B-Annual Report</b>	
	This item was deferred to the November meeting.	
<b>QA.10.21.16</b>	<b>Quality Oversight and Assurance</b>	
<b>QA.10.21.16.1</b>	<b>Quality Oversight and Assurance Profile</b>	
	 <p>QA.10.21.16.1 - Quality Oversight and Assurance Profile</p> <p>JC presented the slides to the Academy and the key points were highlighted:</p> <ul style="list-style-type: none"> <li>• A number of significant events concerning patients presenting with abnormal Neurology to the Emergency Department (ED) have been identified with learning shared both internally and across the organisation.</li> <li>• A Healthcare Safety Investigations Branch (HSIB) National Learning report received has been cascaded across the organisation consisting of a thematic analysis of 22 national investigations and three safety themes.</li> <li>• Videos are being developed with Education and the Electronic Patient Record (EPR) to 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.</li> <li>• Themes have been identified around Yorkshire Ambulance Service (YAS) 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.</li> </ul>	
	<b>Serious Incident (SI) Report</b>	
	<p>JC noted in the last reporting period there were two Serious Incidents declared by Bradford Teaching Hospitals NHS Foundation Trust between 13 September and 17 October 2021:</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• 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 failure.</li> <li>• In accordance with the requirements of HSIB, a maternity related incident was reported via STEIS, SI 2021/19879. An independent investigation will be carried out by HSIB.</li> </ul> <p>One SI has been concluded since the last report:</p> <ul style="list-style-type: none"> <li>• SI 2021/15080 Never Event: Transfusion or transplantation of ABO-incompatible blood components or organs.</li> <li>• 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.</li> <li>• Eight SI investigations are currently ongoing in the organisation.</li> </ul>	

	<ul style="list-style-type: none"> <li>• 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.</li> <li>• An internal audit of patient safety governance processes was commenced in October 2021 by Audit Yorkshire.</li> <li>• Four Central Alerting System (CAS) alerts were received in September of which only one required a response and which is now complete.</li> <li>• There were five external reportable safety events during September.</li> <li>• A monthly Care Quality Commission engagement meeting was held in September.</li> </ul> <p>The Academy was assured the Trust has processes in place to identify, investigate, improve and learn from SIs.</p>	
	<b>Strategic Risks relevant to the Academy</b>	
	<p>An update on the Open Strategic risks was provided by JC:</p> <ul style="list-style-type: none"> <li>• No new risks have been added to the Risk Register for the Academy.</li> <li>• Four risks require a review.</li> <li>• All risks have appropriate mitigation in place and three were highlighted in detail.</li> <li>• Risk 3104 – The second of four telephony migrations has been completed successfully. The old system is noting to be failing for no explicable reason, the migration is being managed closely by the Command Centre.</li> <li>• 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.</li> <li>• Risk 3357 regarding theatre ventilation remains open. Significant work is underway throughout all theatres, this is a long-term project.</li> <li>• Regarding Risk 3380, MH queried whether the Trust is continuing to provide Pharmacy services for Bradford District Care Foundation Trust via a Service Level Agreement. JC will confirm this or otherwise with MH following the meeting.</li> </ul> <p>The paper was accepted by the Academy.</p>	QA21076 Associate Director of Quality JC
<b>QA.10.21.16.2</b>	<b>Quality and Patient Safety Academy Dashboard</b>	
	 <p>QA.10.21.16.2 - Quality Dashboard - 5</p> <p>MH noted the dashboard is work in progress and is currently under review with a number of areas within the dashboard having already</p>	



	<p>been discussed earlier in the meeting.</p> <p>KD noted the following on behalf of herself and RS:</p> <ul style="list-style-type: none"> <li>• 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. The suggestion of a refresher Board Development session on HMSR and SHMI was agreed to be beneficial.</li> <li>• Category 3 pressure ulcers have taken a downturn, however, there are increasing numbers of patients on ventilation and non-invasive ventilation. This figure may increase in relation to the continued use of face masks and endotracheal tubes.</li> <li>• Falls with harm continue to reduce.</li> <li>• Staffing challenges across the board eg locally, regionally and nationally, were discussed at the People Academy on 27 October 2021. Mitigation is noted to be in place.</li> </ul> <p>JC suggested it may be useful to have a discussion on Mortality presented at the QPS Academy and at the Board of Directors to understand the Trust's position and the work underway around structured judgement reviews and learning from deaths.</p> <p>The report was noted by the Academy.</p>	<p>QA21077 Chief Medical Officer RS</p> <p>QA21078 Associate Director of Corporate Governance/ Associate Director of Quality LP/JC</p>
<b>QA.10.21.17</b>	<b>Safeguarding Adults Quarterly Report</b>	
	This item was deferred to the November meeting.	
<b>QA.10.21.18</b>	<b>Safeguarding Children Quarterly Report</b>	
	 <p>QA.10.21.18 - Safeguarding children</p> <p>JS was welcomed to the meeting to present the quarterly report.</p> <p>The key points were highlighted around learning, improvement and assurance.</p> <ul style="list-style-type: none"> <li>• Training compliance has improved for Safeguarding children over all levels despite the pressures of Covid over the last twelve to fourteen months.</li> <li>• Additional expert Child Exploitation (CE) training has been provided following the release of the Thematic Child Sexual Exploitation (CSE) review.</li> <li>• Team now proactive in commencing additional training and other actions prior to reports/action plans/recommendations being published.</li> <li>• Adults and Children Safeguarding team contributed to safeguarding week with the theme being domestic abuse.</li> <li>• Main challenge is around the Mental Health Crisis pathway for children and young people.</li> <li>• Challenges of the Crisis pathway introduced in April 2021 for children and young people being cared for on the ward.</li> </ul> <p>Development of the multi-agency crisis pathway is assisting the</p>	

	<p>Trust to move towards a better position for the young people in terms of escalation processes to find the right placement for these children.</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• Voluntary services are working daily in the Trust as part of a new twelve month pilot in ED looking at violence reduction, with these children now being flagged on the Electronic Patient Record (EPR).</li> <li>• The Royal College of Paediatrics and Child Health National Standards for child protection medicals/safeguarding medical guidance was released earlier in the year. The Trust has its own action plan and an audit is in progress with most areas currently identified as 'green'.</li> <li>• 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.</li> <li>• An internal audit by Audit Yorkshire in Summer 2021 looking at children's safeguarding in the Trust has been completed and high assurance was received.</li> </ul> <p>MH questioned how the Trust could, as noted in the paper, provide continued support. JS noted 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.</p> <p>KD noted the phenomenal work by the team, on limited resource, to protect paediatric patients. KR has undertaken excellent work with her team in caring for these vulnerable, poorly and at risk age group. The work across Bradford and the Trust has been exceptional.</p> <p>The report was noted.</p>	
<b>QA.10.21.19</b>	<b>Any Other Business</b>	
	There was no other business to discuss.	
<b>QA.10.21.20</b>	<b>Matters to share with other Academies</b>	
	<ul style="list-style-type: none"> <li>• IPC Quarter 2 Progress Report.</li> </ul>	
<b>QA.10.21.21</b>	<b>Matters to escalate to the Board of Directors</b>	
	<ul style="list-style-type: none"> <li>• IPC Quarter 2 Progress Report.</li> <li>• Patient Safety Strategy/Patient Safety Specialists.</li> <li>• In-patient Survey.</li> <li>• Mortality.</li> </ul>	

	<ul style="list-style-type: none"> <li>KD requested all the issues discussed regarding good practice be documented in the Chair's report to the Board of Directors.</li> </ul>	QA21079 Head of Corporate Governance JM
	<b>Date and time of next meeting</b>	
	Wednesday, 24 November 2021, 2 pm to 5 pm	
	<b>Annexes for the Quality and Patient Safety Academy Annex 1 – Documents for Information</b>	
QA.10.21.22	<b>Patient Experience Quarterly Report including Complaints and Parliamentary Health Service Ombudsman (PHSO) Report</b>	
	Noted for information.	
QA.10.21.23	<b>Infection Prevention and Control (IPC) Report – Quarter 2</b>	
	Noted for information.	
QA.10.21.24	<b>Infection Prevention and Control (IPC) Board Assurance Framework (BAF)</b>	
	Noted for information.	
QA.10.21.25	<b>Quality Academy Structure Chart</b>	
	Noted for information.	
QA.10.21.26	<b>Quality Academy Workplan</b>	
	Noted for information.	
QA.10.21.27	<b>Quality Oversight and Assurance Profile</b>	
	Noted for information.	
QA.10.21.28	<b>Serious Incident Report</b>	
	Noted for information.	
QA.10.21.29	<b>Strategic Risks Relevant to the Academy</b>	
	Noted for information.	

## ACTIONS FROM QUALITY AND PATIENT SAFETY ACADEMY – 27 October 2021

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
QA21049	30.06.21	QA.6.21.19	<b>Estates and Facilities Quarterly Service Report</b> All equipment in the Trust should be documented due to previous significant safety incidents in relation to equipment. RH noted the purchase of new kit by Education and requested whilst records are held in Education, it would be helpful if Clinical Engineering had oversight of this equipment, following their recent assistance with kit during the Covid pandemic. RH will contact CD to discuss further.	Head of Education/ Education Manager	November 2021	28.07.21: Deferred to the September meeting. CD/AH emailed for follow-up. 20.10.21: Education awaiting further details from Estates and Clinical Engineering. Update to be provided at the November meeting. 17.11.21: No further update.
QA21040	30.06.21	QA.6.21.5	<b>Service Presentation – Infection Prevention and Control with Focus on Sepsis</b> KD noted PR and his team will link with CC around the sepsis dashboard to ensure meaningful sepsis data is available on the overarching dashboard.	Chief Information and Digital Officer	November 2021	28.07.21: PR has a meeting scheduled in August. 27.10.21: PR noted ongoing conversations with CC to ensure the correct information is captured on the EPR around the management of sepsis. RS confirmed audits have been undertaken which have confirmed that patients are getting the correct treatment. LAE noted the ongoing work with the coding team and the work streams linked with this.
QA21011	24.02.21	QA.2.21.7	<b>Quality Oversight and Exception Profile</b> An update on the work with Airedale will be included in the Quarterly report submitted in April.	Associate Director of Quality	November 2021	28.04.21: JC - Met with Airedale and mapping work is being progressed. Resources will be identified to support the work required. A go-live

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
						date sometime after October 2021 is envisaged, dependent on mapping. JC will provide an update at the October Quality Academy relating to Datix. 20.10.21: JC will update further when the programme progresses. 27.10.21: JC noted this issue concerns Airedale's Datix capability. JC will discuss the programme with Airedale.
QA21060	29.09.21	QA.9.21.5.2	<b>Quality Oversight and Assurance Profile</b> The Maternal Death Incident SBAR report and the Healthcare Safety Investigation Branch – Maternity Investigation 2011-2672 – August 2021 reports noted. The outcomes and significant learning identified from the report around discharge information is not reflected in the Trust document however it was noted this has been actioned and will be discussed with Maternity.	Associate Director of Quality	November 2021	17.11.21: JC and Carly Stott to discuss.
QA21066	29.09.21	QA.9.21.10	<b>Introducing the Electronic Patient Record (EPR) into Maternity Services – Update</b> MH suggested a risk around capacity of the EPR team to support the Trust is captured on the risk register.	Director of Midwifery	November 2021	16.11.21: SH - There is a risk already on the project risk register being monitored through weekly Business As Usual (BSU) team meetings and a separate weekly change request meeting. The agreement is that if the BAU team do not have capacity then external resources will be sourced to perform the work. Completed.

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
QA20168	29.09.21	QA.9.21.19	<b>Matters to escalate to the Board</b> To inform the Board the finalisation of the Terms of Reference and the Work plan will take longer to complete due to a Development session being organised.	Associate Director of Corporate Governance/ Board Secretary	November 2021	15.10.21: To be included in the Academy Chair's report to the Board on 18 November 2021. Completed.
QA21069	27.10.21	QA.10.21.5	<b>Service Presentation – Quality in Urgent and Emergency Care</b> RS, KD and JC agreed that the following would be picked up in a future Executive to Clinical Business Unit meeting: <ul style="list-style-type: none"> <li>The top three risks.</li> <li>How the Unit ensures lessons are being learned.</li> <li>Training programmes.</li> <li>Triage, resuscitation and paediatric induction.</li> </ul>	Chief Medical Officer/Chief Nurse/ Associate Director of Quality	November 2021	16.11.21: Completed.
QA21070	27.10.21	QA.10.21.6	<b>Maternity Services Update</b> SH agreed to provide an update in the next report on: <ul style="list-style-type: none"> <li>Vaccination rates in pregnant women.</li> <li>The challenges around SIs in relation to Black and Mixed Ethnicity (BAME) patients.</li> </ul>	Director of Midwifery	November 2021	16.11.21: SH - Vaccination rates in pregnancy are not held at CBU level as there is no recording mechanism. The CBU continues to work closely with the Maternity Voices Partnership to encourage vaccine uptake. Clinicians recommend and provide vaccination information regularly during pregnancy. SH will include the proportion of BAME women whose care required an SI during the last 12 months in the December/January Maternity update. Completed.



Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
QA21071	27.10.21	QA.10.21.8	<b>Magnet4Europe</b> The report was noted by the Academy and MH requested sight of the project timeline. <b>Post-meeting noted</b> – Project timeline slide added.	Director of Nursing	November 2021	10.11.21: Completed.
QA21074	27.10.21	QA.10.21.13	<b>Patient Experience Group Highlight Report including Complaints and Parliamentary Health Service Ombudsman (PHSO) Report</b> Further details will be provided at the November 2021 QPS Academy on the in-patient survey results.	Assistant Chief Nurse	November 2021	11.11.21: Item on the November agenda. Completed.
QA21075	27.10.21	QA.10.21.14	<b>Infection Prevention and Control (IPC) Report – Quarter 2</b> MH suggested this study be shared with other Academies and the Board of Directors.	Associate Director of Corporate Governance	November 2021	16.11.21: LP - To be circulated via email. Completed.
QA21076	27.10.21	QA.10.21.16.1	<b>Strategic Risks relevant to the Academy</b> Regarding Risk 3380, MH queried whether the Trust is continuing to provide Pharmacy services for Bradford District Care Foundation Trust via a Service Level Agreement (SLA). JC will confirm this or otherwise with MH following the meeting.	Associate Director of Quality	November 2021	17.11.21: No current Pharmacy SLA with the Care Trust, service taken back by Bradford District Care Foundation Trust in December 2019. Completed.
QA21077	27.10.21	QA.10.21.16.2	<b>Quality and Patient Safety Academy Dashboard</b> The suggestion of a refresher Board Development session on HMSR and SHMI was agreed to be beneficial.	Chief Medical Officer	November 2021	10.11.21 - RS has sent details to the Chair of the Board of Directors regarding a training session on Mortality which will be shared with the Non-Executive Directors. Completed.
QA21079	27.10.21	QA.10.21.21	<b>Matters to Share with the Board of Directors</b> KD requested all the issues discussed	Head of Corporate Governance	November 2021	11.11.21: Chair's report for Board of Directors 18.11.21. Completed.

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
			regarding good practice be documented in the Chair's report to the Board of Directors.			
QA21046	30.06.21	QA.6.21.13	<b>Patient Translational Research Centre – Patient Involvement in the Investigation of Serious Incidents</b> JOH agreed to update the Academy in six months' time.	Improvement and Clinical Outcomes Lead	January 2022	
QA21061	29.09.21	QA.9.21.5.2	<b>Quality Oversight and Assurance Profile</b> MH raised the ongoing incident MHRA 021/008/019/401/002 around the Desflurane Anaesthetic Agenda and the return of empty vapouriser(s). JC will discuss with MH who offered assistance.	Associate Director of Quality	January 2022	20.10.21: JC - Awaiting discussion. 27.10.21: Further to MH's discussions with a research colleague. MH and JC will arrange to meet.
QA21072	27.10.21	QA.10.21.10	<b>Patient Safety Strategy Update</b> In due course, all staff will require training around patient safety and training programmes are being devised nationally and plans developed to identify how training is managed, with the Education team and subsequently rolled out to staff. It is envisaged all training will be on line and recorded through ESR mandatory training records, with different levels of staff accessing different levels of training. LAE envisaged an update would be available in three months.	Deputy Chief Medical Officer/ Associate Director of Quality	January 2022	17.11.21: JC – In train but do not have a date for implementation. Information will be logged through ESR.
QA21078	27.10.21	QA.10.21.16.2	<b>Quality and Patient Safety Academy Dashboard</b> JC suggested it may be useful to have a discussion on Mortality presented at the QPS Academy and at the Board of Directors to understand the Trust's position and the work	Associate Director of Corporate Governance/ Associate Director of	January 2022	16.11.21: LP – To be included on the January 2022 QPS Academy agenda.



## Bradford Teaching Hospitals

NHS Foundation Trust

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
			underway around structured judgement reviews and learning from deaths.	Quality		
QA21073	27.10.21	QA.10.21.10	<b>Patient Safety Strategy Update</b> The Academy noted the report and agreed to further discussions and a mapping exercise around the quality priorities at the development session on 18 February 2022.	Associate Director of Quality	February 2022	
QA21080						