

Board of Directors			
Date	10 March 2022	Agenda item:	Bo.3.22.8

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 23 February 2022		
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 23 February 2022		
Previously approved at:	Committee/Group	Date	
	N/A		

Key Matters Discussed

The Quality and Patient Safety Academy met on 23 February 2022. A summary of the key items discussed is presented below. The confirmed minutes from the meeting held in February will be available at Board in May 2022. The next meeting of the Quality and Patient Safety Academy is scheduled for 30 March 2022.

Meeting held 23 February 2022: Key items discussed.

1. Matters Arising: Shared Academy Chair Role

Professor Janet Hirst and I have agreed that we would each chair three consecutive meetings of the Academy as part of our joint Academy chairing role. As such Professor Hirst will be chairing the next three meetings (March, April and May).

2. Update on Items deferred (from the January meeting)

The Academy will be in receipt of the reports on 'Embedding Kindness and Civility and, ReSPECT in March 2022. The one remaining item still to be rescheduled is the Neonates Service update.

3. Service Presentation: Cardio Physiology

Cardio-Physiology has to date experienced a 40% increase in the demand for echocardiography whilst also seeing changes in the technical complexity of the procedure. Joanne Ashton, Head of Cardiology provided a clear overview of the service challenges where waiting times for outpatient echocardiographs were at 6 weeks and inpatient waiting times were described as 'unacceptably long' at between four and five days. The service has made excellent improvements via a number of routes, including a willingness to adopt new ways of working. The service has changed clinical pathways, secured capital investments and successfully accessed external funding schemes to both improve and update technology. Importantly however the investments in staff recruitment, training and development were pleasing to hear as these supported benefits to patient safety, experience and treatments. These investments include:

- Recruitment of a trainee cardiac healthcare practitioner specifically for echocardiography
- Securing funding awards for, two trainee clinical scientists specialising in cardiac imaging, one trainee echocardiographer and funding to improve the clinical skills of senior staff.

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- Introduction of bi-monthly education sessions which include elements of clinical audit and education and supporting staff to undertake the BSE accreditation process.

The team has increased the slot times for echocardiograph and, empowered the echo-cardiographers to vary procedures where required. Reporting has improved and the team are planning a patient satisfaction survey via an internal QI process.

Targets and challenges remain which include, working at full capacity and, ensuring the right levels of staffing by appropriately qualified and accredited staff. The team has identified that they require a designated cardiac healthcare science trainer and they are also seeking to find substantive posts for all the trainees that they have in the system.

This was an enlightening and interesting deep dive into one of our key services with their journey and experiences presented in a clear way. Of key interest to the Academy were the funding opportunities available to support developments and it was noted that other services were also sighted on, and taking advantage of, funding sources available to support their own service developments.

4. Translational Research update: Research Programme on Patient and Family Involvement in Safety Incident Investigations (PFISII)

The overview of and outcomes to date from the research programme was welcomed by the Academy. What is particularly evident is the value of the co-design approach. The researchers described the improvements they were seeking and their learning to date. Initial data analysis has highlighted three key areas of importance in relation to patient and family involvement in investigations which are;

- Maintaining contact.
- The inclusion of the voices of patients, families and staff to ensure they are not forgotten.
- The provision of support as the needs of those involved in investigations will change over time.

The research programme was undertaken as part of five live investigations here at BTHFT and made use of observations, interviews and participant diaries. The outcomes from the programme will be used to enable more effective engagement in safety incident investigations. The Academy commends the work undertaken to date.

5. Magnet4Europe

The Academy received a comprehensive update on progress with programme which aims to test the feasibility and sustainability of the model in European Healthcare Organisations. As a reminder it involves the redesign of hospital workplaces to improve the mental health and wellbeing of nurses and physicians to improve patient safety.

The discussion focussed on the implementation of the 'Magnet Standards' and the aim for all registered nurses to have a degree in nursing. Whilst it was acknowledged that having a degree brought with it certain disciplines that supported higher level report writing for example, the Academy did differ with the Magnet view that this required a degree specifically in nursing. Sally Scales, Director of Nursing and Programme Lead for Magnet has expressed this view to the Magnet team however they are not changing their position. The current focus here at BTHFT is on the implementation of the standards and the others identified include:

- Nursing & Midwifery Strategy
- Implementation of Shared Governance for Nursing
- Creating a Process Improvement (QI) culture
- Establishing an effective transition to practice model for all roles

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- Establishing nursing certification
- Improving nurse retention

The next update will be provided to the Academy in June 2022.

6. Learning from Deaths/Mortality Review Improvement Programme

Dr Michael McCoee, Associate Medical Director provided a detailed report on the improvement programme which is aimed intrinsically at what BTHFT can learn from deaths and make improvements to lower the rate of unavoidable deaths. The two measures used are the Hospital Standardised Mortality Rate (HSMR) and the Standardised Hospital Mortality Index (SHMI). In December 2021 BTHFT had an HSMR of 93 which shows that we are performing better than expected according to these mortality indices, and our SHMI was 104 which shows we are performing as expected. Whilst these established ratings provide some measure of assurance with regard to the level of unavoidable deaths they do not provide assurance with regard to the quality of care that is encountered by patients. The Academy received further details with regard to regard to the work underway which focussed on learning and improvement and in particular noted the following key highlights;

- The guidance used developed by the National Quality Board to provide a framework for trusts and foundations trusts in identifying reporting, investigating and learning from deaths. This gave rise to the Structured Judgment Review (SJR) which was developed with BTHFT. This methodology is now adopted by a large majority of hospitals across the UK. Crucially, the reviews highlight good care and here at BTHFT 97% of our patients receive good care.
- There are also opportunities for a direct link to quality improvement to identify and address any issues. The SJR also supports collaboration with the work of the Medical Examiner.
- Development of an MDT approach. The skill set across our organization in the Allied health professions and nursing will support quality reviews in relation to the quality of care provided.
- The establishment of a new mortality improvement group to focus on assurance through detailed scrutiny of the content of reviews and working with the Quality Improvement team to support the dissemination of learning and embedding of improvements.
- BTHFT is working in partnership with the Better Tomorrow team from NHSE/I on the national agenda. It is anticipated that as part of this work BTHFT, in collaboration with Sheffield Teaching Hospitals, is expecting to run a pilot focussed on 'explicit links between the findings from reviews and the embedding of improvements'. The Academy noted that Dr Maxwell McLean, Chairman has agreed to be the nominated 'Non-Executive Director' for the Better Tomorrow team.
- Requests have also been received to work collaboratively from the District Care Trust and the CCG.

The Chief Medical Officer emphasised the opportunity that the Trust now has, as a consequence of the appointment of the Medical Examiner, for the scrutiny of every single death by a senior clinician to ensure that they are directed through the most appropriate channel (coroner or SJR) or whether in fact it was an entirely predictable death that we can learn from and improve.

It is pleasing to note that the team are leading the way in this work and the Academy looks forward to receiving its next update in July 2022.

7. Clinical Outcomes Group Highlight Report: Consent

The Academy discussed with Dr Padma Munjuluri, Associate Medical Director (and the lead for Consent), the actions being taken in response to the limited assurance Internal Audit report which had also been discussed in detail at the Audit Committee on 2 February 2022.

Dr Munjuluri outlined the scope of the audit, the data collected and, the areas where excellent

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practice had been identified. With regard to the key issues, one of those identified was that EPR did not have the ability to collect consent and as such this activity remained paper based which presented key issues of its own.

The Academy noted that the areas of focus for the improvement work fall within three key areas which were covered in good detail by Dr Munjuluri. In summary these were;

- Patient information (ensuring that it is relevant and current, tailored to need, inclusive, in easy read formats and other languages)
- Consenting Process (changes identified to; generic consent forms, patient agreement statements and, seeking to minimise variation across specialties)
- Opportunities (around E-consent, the development of a patient portal, co-designing and, the development of a perioperative package).

The Academy was assured by the actions described by Dr Munjuluri in response to the limited assurance Internal Audit Report.

With regard to EPR, the Academy was advised that E-consent was left out of the original EPR deployment because of its complexity and the risks surrounding it. There are now third party solutions which have been developed and do work well with Cerner. A business case has been approved in principal by the Executive Management Team, pending the outcome of investigations into the functionality modules. The modules have patient information embedded in them and the Executives are waiting to see if these can be utilised for Consent before committing to an additional funding solution.

8. Quality Oversight and Assurance:

The Academy noted the contents of the comprehensive suite of documents which included; the Quality Oversight and Assurance Profile; the Serious Incident Report and the High level risks relevant to this Academy. The key discussion covered the high level risks and a number of items from the oversight and assurance reporting. With regard to the risks in particular, the Academy noted the following:

- Risk 3741 regarding unvaccinated staff. This risk would remain until notification as received with regard to the repeal of the law.
- Risk 24211 originally raised in 2014, concerning kidney dialysis. Further concerns have been raised by the Renal Team as there have been a couple of incidents at Skipton Dialysis Unit. A feasibility study is being undertaken to consider a series of options on how to provide the service differently and the risk will be prioritised within the 2022/23 Capital programme. There are plans in place as to the Trust's actions if there was a catastrophic failure
- Staffing Risks. The Academy noted the full discussions that had taken place at the People Academy regarding those risks relating to staffing issues and the expected future pressures.

9. Outstanding Maternity Services (OMS) update

The Academy received a high level summary of the report from Alison Powell, Midwifery Lead for the OMS and noted the varying degrees of progress and challenges since November 2020 up to 2022.

An issue was highlighted by Professor Janet Hirst that had been previously reported at the Finance and Performance Committee under their agenda item covering the Financial Plan Review. There was a risk flagged with regard to Maternity in relation to the proposed flow of funding from the ICS for the local maternity system. Providers had been asked to use a particular model which allocated funding based on 'birth rates only' with no account taken of the health of the local population or other population inequalities. The outcomes from this particular modelling

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presented a risk to our BTHFT spending plans to the tune of £4.2m. If this stands then there is a risk to the delivery of our services and the aspirations that we have for our Maternity services. The Midwifery Lead advised that mapping work had recently been undertaken related to 'continuity of care' which showed that 53% of our population are located within the most deprived areas. The modelling approach described for the allocation of funding is not evidence based. The Academy agreed that this should be escalated to the Board of Directors and would continue to be tracked at the Quality and Patient Safety Academy.

10. Update on Introducing the Electronic Patient Record (EPR) into Maternity Services

The Academy was pleased to note the position with regard to the EPR Maternity and Fetalink Implementation Project. In summary;

- Testing had now been completed
- A full dress rehearsal would take place during the first week in March to support safe switching to the new solution.
- Staff training had commenced at the end of January 2022
- The work underway with Communications Team to ensure all of our stakeholders are kept informed
- The Go Live preparations underway for the launch date of 26 March 2022.

The implementation of Cerner maternity will provide a single system for Maternity services, providing trust wide oversight of the maternity care our Trust provides. Not having an electronic storage of CTG has previously been highlighted by the CQC. This system will address that concern and provide improved mandatory reporting for the Maternity services data set. There will be better access for personalized care plans for women and improved oversight of the whole maternity journey. Women currently go from an electronic system to a paper system to an electronic system and back to a paper system. Having an end to end system will improve safety and provide efficiencies.

With reference to the earlier agenda item on Consent; the Academy noted that the team is looking at developing a patient portal in response to requests from the women consulted with as part of the development of the Maternity EPR. Whilst it is currently outside the scope of this project the Maternity team is working with the Informatics team to provide this at some point.

The Academy members look forward to undertaking a site visit to view the system following its launch and once restrictions in relation to the pandemic are further relaxed.

11. Any Other Business

Final approval and ratification was provided for the following two Pharmacy related policies having noted that they had been reviewed through internal Trust governance processes.

- Medicines Policy
- Controlled Drugs Policy

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:

- Item 3. Service Presentation: Cardio Physiology
- Item 6. Learning from Deaths/Mortality Review Improvement Programme
- Item 10. Update on Introducing the Electronic Patient Record (EPR) into Maternity Services

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

Matters escalated to the Academies or Board of Directors for consideration

The Academy is escalating to the Board the significant risk to BTHFT's maternity services proposed funding following the ICS modelling used to determine the funding allocations.

New/emerging risks

There were no new risks however there may be one emerging risk related to the proposed Maternity services funding allocation.

Recommendation

The Board is requested to note the discussions and outcomes from the Quality and Patient Safety Academy held on 23 February 2022.