| Board of Directors | | | |
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| **Date** | **20.01.22** | **Agenda item:** | **Bo.1.22.11** |

# Report from the Chair of the Quality and Patient Safety Academy

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| **Presented by** | Janet Hirst, Non-Executive Director, Academy Deputy 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 24 November 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 24 November 2021 | |
| **Previously approved at:** | **Committee/Group** | **Date** |
| | N/A | |
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**Key Matters Discussed**

The Quality and Patient Safety Academy met on 24 November 2021. Summaries of the key items discussed at the meeting are presented below. The confirmed minutes from the meeting held in November will be available at Board in March 2022. The next meeting of the Quality and Patient Safety Academy is scheduled for 26 January 2022.

**Meeting held 24 November 2021**

**1. Matters Arising**

In considering the Quality and Patient Safety Academy structure; it was noted the whilst there are some slight anomalies to clarify in relation to the reporting arrangements of the sub-groups, it was good to see how this was developing and supporting the level of discussion, debate and activity flowing through to the Academy and up to the Board.

**2. Service Presentation: Dietetics**

A comprehensive and innovative presentation provided by Jackie Loach, Head of Nutrition and Dietetics, led to very interesting discussions that covered:

- Cultural and behavioural challenges,
- The work of the multi-disciplinary nutrition steering group,
- The discussion of measurements of quality through scrutiny of data to improve processes and to demonstrate areas of concern and risk.
- Prioritisation of the continuous development of staff expertise and the evidence base.

The insights provided through this service presentation covered measures implemented following a thorough consideration of the risks. It was excellent to hear of the international insights that also informed the delivery of the dietetics service as well as the positive and proactive improvement models in place. All this has led to a very particular understanding of dietetics today. Assurance was provided with regard to where the system was working well and where improvements were required. This exceptional view of the service was rightly well received by the Academy.

**3. Medical Examiner Role**

On a national level there have been repeated calls for reforms to the death certification process

and the introduction of independent medical scrutiny following several high profile enquiries into significant failings in healthcare that have led to a number of deaths. These high profile enquiries include the Shipman Enquiry, the Francis Report, Morcambe Bay and the Gosport Enquiry. In response, the independent role of the Medical Examiner has been introduced. This role reports through to a regional and national Medical Examiner. Dr Harry Ashurst was introduced to the Academy as the newly appointed Medical Examiner for Bradford and outlined the priorities of his role which are to:

- Provided bereaved families with greater transparency and opportunities to raise concerns and feedback compliments.
- Improve the quality/accuracy of medical certification of cause of death.
- Ensure referrals to coroners are appropriate.
- Support local learning/improvement projects.
- Provide the public with greater safeguards through improved and consistent scrutiny of all non-coronial deaths.
- Contribute and support our Trust Learning from Deaths program

The academy discussed the key challenges which include;

- The move from a weekday only service to a 7 day on-call service
- Funding of future services.
- Consideration of information technology and information governance issues.
- Collaboration with all general practitioners and other healthcare providers and,
- The recruitment of GP medical practitioners with the requisite level of experience

This new important initiative is expected to provide a valuable service to patients' families and the Trusts Learning from Deaths team will link closely with the Medical Examiner's team in the future regarding learning and implementing improvements where necessary.

**4. Estates and Facilities – Quarter 3 Service Report**

A comprehensive report and presentation was provided on current initiatives underway within Estates and Facilities. Key reference was made to the improvements to the site and environment including ward developments, cycle compounds recently installed, new staff changing facilities and, alterations made to ENT theatres including the replacement of ventilation systems. It was particularly pleasing to note that BRI and at Eccleshill Community Hospital have been subject to unannounced food hygiene inspections and both had gained 5 star ratings. An Electronic Workforce Planning system was in development with implementation planned for April 2022 and a Contractor Management Improvement Programme would be rolled out in December 2021. Following a request a the previous Quality and Patient Safety Academy, comparative sustainability information was provided indicating excellent levels for site energy, water volume and carbon emissions per occupied floor area. The challenges were noted with regard to the age of some parts of the estate which has led to the development of the business case for a new hospital in Bradford. This would provide an exceptional opportunity to move towards a more energy efficient hospital/site. The Academy noted that sustainability forms an important part of the Trust's Strategy and is considered in all new projects.

**5. Safeguarding Adults Quarterly report**

The key challenge over the last quarter has been responding to the increase in patients presenting with mental health issues. There has been progress with regard to the delivery of training through online courses and modules namely the We Can Talk Programme (focussed on children). It was also pleasing to note that a training needs analysis had been completed with different levels of training now in development with Education services. The team reported an initial reduction in compliance levels with regard to De-escalation, Breakaway and Restraint

training and analysis is underway to determine if this is as a result of an issue related to training records held on the Electronic Staff Record as the training is delivered by an external provider. This is under investigation by Education services.

The Academy was pleased to note the wide ranging initiatives relating to the appointment of specialist staffing, improvements to the environment and partnership working across the district to better support vulnerable patients. Of particular note was the work underway to look at alternative community based accommodation for children experiencing mental health issues.

**6. Safeguarding Adults Quarterly Report**

The key focus of the discussion concerned the further work required in preparation for Deprivation of Liberty Safeguards and Liberty Protection Safeguards. The Academy noted that further details would be available once the Code of Practice is published. It was noted however that district-wide and regional meetings continue to take place in relation to the Liberty Protection Safeguard changes and a draft provisional District plan has been produced in collaboration with the Clinical Commissioning Group (CCG), Local Authority and other provider partners. Here at the Trust work also continues with the Education team to ensure that all training undertaken is record so that the Trust is able to demonstrate compliance in this area.

**7. Inpatient Survey**

The Academy received a comprehensive report on the results of the CQC National Inpatient Survey (which ran from January 2021 to May 2021) and covered the experience of patients discharged in November 2020. The Academy noted that at that time our region was at the height of the second wave of the Covid pandemic. The results from the survey which were benchmarked nationally were however disappointing. The Academy discussed the full survey results and benchmarking information in detail. There were four main areas in the survey where the Trust had been noted to be worse than other Trusts related to pain, food, communication and discharge planning. Learning, assurance and improvement were discussed in each of these areas and action plans and improvement projects have been identified to address the specific questions and will form the adult in-patient CQC survey improvement action plan. Assurance work has been underway since the survey was conducted and it is hoped that these will make a difference with regard to future results.

This was a helpful and insightful discussion. The Academy did note the positive patient feedback received in a number of other areas and acknowledged that the results should be reviewed in context with other data.

**8. Digital Bi-Annual Report**

Despite working through a challenging time, the digital and data team at Bradford continue to support front-line care and develop the organisation's digital capability. It was pleasing to note the progress with regard to the development of the digital infrastructure and the projects underway to enable staff to deliver daily safer care, gather information and work smarter. Key highlights from the presentation and discussion included:

- The telephony infrastructure improvements
- Upgrades to Windows 10 and office 365
- Electronic Patient Record (EPR)Upgrades
- The agreement of a joint three month prioritisation plan for EPR improvements with Calderdale and Huddersfield NHS FT.
- Maternity migration to EPR completion date of March 2022
- The successful bids to support the replacement of Cardiology systems across place, to extend

EPR functionality to add a comprehensive surgical application suite and to deliver the peri-operative digital transformation programme.
- Projects across West Yorkshire and the Integrated Care System were noted, e.g. a joined up care record for Yorkshire and the Humber.
- Pathology programme which amongst other projects will replace the aged Laboratory Information System with this upgrade is taking place next autumn, to improve the Joint Venture between BTH, Airedale and Harrogate.
- Developments with regard to Business intelligence and improved and more accurate reporting providing real time data; in particular, clinical coding engagement with Getting It Right First Time (GIRFT) and Quality Improvement (QI) to improve documentation and data accuracy.
- The Digital Forum in place to address the complexities surrounding the sharing of information with partners and sensitivities that needed to be addressed with regard to historical information.

**9. Patient Safety Group Highlight Report**

The purpose of the Patient Safety group is to scrutinise the safety elements of the organisation and to report to the QPS Academy in respect of assurance, learning and improvement relevant to patient safety. The key outcomes (from the meeting held earlier in November) included:
- Discussion with care groups around recruitment strategies and patient safety.
- Duty of Candour Policy.
- Reliable systems and processes and responding effectively to safety issues
- Immediate learning from Serious Incidents (SIs).
- Completion of the EPR discharge process work to improve discharge and discharge summaries, medicine safety, and the use of deteriorating patient data.
- Medicines Safety newsletter published and the launch of the Good Catch.
- Falls improvement work ongoing and the testing of a hot debrief process.
- Medicine Safety group review of areas for improvement
- The work undertaken by Speech and language therapy to understand areas of improvement.
- Update on the Outstanding Theatre Improvement Programme launched in October 2021.

**10. Quality Oversight and Assurance Profile**

The monthly summary of assurance processes covered updates on the following:
- The Quality Improvement (QI) key priorities from the Quality Account 2020/21 continue to be progressed.
- The Outstanding Maternity Services Programme celebrated its first birthday with the amazing work to date recognised.
- The work that has commenced to identify work streams and develop charters, aims and objectives for the outstanding Theatres Services programme which launched in mid-October.
- QI training with Quest that has commenced with a team in Radiology and Dietetics.
- The receipt of the assurance report from the Medicine Healthcare Products Regulatory Agency Inspection which took place on 19 October 2021 and the response that is currently being completed.

An update on the assurance report would be provided at the next Academy meeting.

**11. Serious Incident (SIs) Report**

There are nine SIs currently in progress with four extension requests submitted to the Bradford and Craven Clinical Commissioning Group (CCG). In the last reporting period;
- SI 2021/22853 was declared which related to abuse/alleged abuse of an adult patient by a third party. Immediate actions and learning were put in place which included oversight of all

the patients on site who require an extra level of supervision either from Security or Nursing staff.

Two Maternity related incidents were reported. The independent investigations are being carried out by the Healthcare Safety Investigation Branch (HSIB) as per requirements:

- SI 2021/21502 - Maternity/Obstetric incident meeting SI criteria: baby only. Baby born at 41 weeks and 4 days gestation and transferred to the Neonatal Unit for therapeutic cooling.
- SI 2021/22079 – Maternity/Obstetric incident meeting SI criteria: baby only. Baby born at home. Resuscitation attempted, however, this was unsuccessful and the case has been referred to HM Coroner.

Since the writing of the report two further incidents have been declared. The first relating to a patient who developed a category 4 pressure ulcer and the second regarding the closure of the Neonatal Unit to external admissions due to a number of babies testing positive for a Klebsiella infection. The Academy was assured by the immediate and comprehensive learning noting the Trust has processes in place to identify, investigate, improve and learn from SIs.

**12. High Level Risks relevant to the Academy**

No new risks have been added this month, no risks require review and, that all appropriate mitigation is in place (as per the document presented).

The Chief Medical Officer advised that the MHRA response has been completed in relation to the October inspection of the Blood Transfusion Laboratory. An action plan has been submitted and a response from the MHRA is awaited.

A new Breast Screening machine has caused some concern as to the quality of images and is in the process of being calibrated. The delay in the calibration has been due to the Covid pandemic as the team is required to travel from Italy to carry out the work. Following calibration a decision will be made as to whether the equipment is fit for purpose or should be replaced.

**13. Quality and Patient Safety Academy Dashboard**

Focus was placed on metrics provided by exception. The key items discussed covered:

- Readmissions which have been significantly affected by Covid and the reduction in elective activity. It may be some months before the steady-state for readmissions is understood.
- In terms of antibiotic treatment of sepsis and sepsis screening of patients; there is an anomaly in the EPR recording process as highlighted at previous QPS Academy meetings. Work is ongoing to improve the process. The Chief Medical Officer provided reassurance that audits have demonstrated that patients are still receiving the correct care despite the low screening numbers.
- With regard to pressure ulcers, incidents are above average due to the high numbers of patients requiring non-invasive ventilation. At the Covid peak approximately 40 to 50 in-patients were on non-invasive ventilation. Numbers have reduced considerably and it is hoped that this trend continues.
- As a result of the frequent reconfiguration of wards over the last 18 months anomalies have been noted in relation to Venous Thromboembolism screening. Some wards are exempt from screening however data is being analysed to ensure an accurate reflection of current practice.

**14. Infection Prevention and Control Board Assurance Framework**

The following key outcomes were highlighted form the discussion held which focussed on the current position on hospital onset Covid cases. The key areas discussed covered:

- An identified outbreak on the stroke ward in October, following investigation, identified this resulted from a patient admitted in September. All hospital patient contacts were screened resulting in identification of four further cases. Immediate actions and routine processes were implemented following discussion with Silver Command including patient isolation, re-swabbing as per protocols, cleaning regimens and inspections. Gaps were identified in the swabbing protocol leading to the introduction of Covid champions. Concerns and solutions relating to ventilation during the winter period were noted due to the absence of a mechanical ventilation system. Ward restrictions remained until all bays affected were emptied enabling a deep clean.
- Data provided by NHS England indicated that the North East and Yorkshire remain high outliers for hospital onset Covid positive cases greater than 15 days however BTHFT remains one of the lowest in the region for the number of hospital onset Covid cases.

This detailed and reassuring report demonstrates the ways in which this service is being modernised and the Academy congratulated the Infection and Prevention Control team on maintaining low rates of Covid infection.

**15. Research Activity within the Trust**

The Academy noted the detailed report and referenced the recent presentation to the Board earlier in November by Professor John Wright and the Chief Medical Officer highlighted the work ongoing at Bradford Institute of Health Research to develop the Research Strategy.

**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. The service presentation received covering Dietetics
2. The new role of the Medical Examiner
3. The Inpatient Survey and the detailed plans for improvements
4. The extensive Digital Bi-Annual Report
5. Infection Prevention and Control Board Assurance Framework

The Academy is 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 Board of Directors for consideration**

There were no new matters to escalate to the Board.

**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 24 November 2021.