


## QUALITY AND PATIENT SAFETY (QPS) ACADEMY MINUTES


<b>Date:</b>	Wednesday, 26 January 2022	<b>Time:</b>	14:00-15:30
<b>Venue:</b>	Microsoft Teams meeting	<b>Chair:</b>	Mr Mohammed Hussain (MH), Non-Executive Director/Joint Chair
<b>Present:</b>	<p><b>Non-Executive Directors:</b></p> <ul style="list-style-type: none"> <li>- Professor Janet Hirst (JH), Non-Executive Director/Joint Chair</li> <li>- Mr Jon Prashar (JP), Non-Executive Director</li> <li>- Mr Mohammed Hussain (MH), Non-Executive Director</li> <li>- Mr Altaf Sadique (AS), Non-Executive Director</li> </ul> <p><b>Executive Directors:</b></p> <ul style="list-style-type: none"> <li>- Ms Karen Dawber (KD), Chief Nurse</li> </ul>		
<b>Attendees:</b>	<ul style="list-style-type: none"> <li>- Dr LeeAnne Elliott (LAE), Deputy Chief Medical Officer</li> <li>- Mrs Claire Chadwick (CC), Nurse Consultant/Director of Infection, Prevention and Control</li> <li>- Ms Liz Tomlin (LT), Head of Quality Improvement (QI) and Clinical Outcomes</li> <li>- Ms Louise Horsley (LH), Senior Quality Governance Lead</li> </ul>		
<b>In Attendance</b>	<ul style="list-style-type: none"> <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>	There were no observers.		

Agenda Ref	Agenda Item	Actions
QA.1.22.1	<b>Apologies for Absence</b>	
	<ul style="list-style-type: none"> <li>- Dr Ray Smith (RS), Chief Medical Officer</li> <li>- Ms Judith Connor (JC), Associate Director of Quality</li> <li>- Dr Paul Rice (PR), Chief Digital and Information Officer</li> </ul>	
QA.1.22.2	<b>Declarations of Interest</b>	
	There were no declarations of interest.	
QA.1.22.3	<b>Minutes of the meeting held on 24 November 2021</b>	
	<p>The minutes of the meeting held on 24 November 2021 were approved. The action plan was discussed and updated as required.</p> <p>The Academy noted that the following actions had been concluded:  QA21040 – QA.6.21.5 (30.06.21) – Service Presentation – Infection Prevention and Control with Focus on Sepsis.  QA21049 – QA.6.21.19 (30.06.21) – Estates and Facilities Quarterly Service Report.  QA21060 – QA.9.21.5.2 (29.09.21) – Quality Oversight and Assurance Profile.  QA21072 – QA.10.21.10 (27.10.21) – Patient Safety Strategy Update.</p>	

	QA21081 – QA.11.21.4 (24.11.21) – Matters Arising – Quality and Patient Safety Academy structure chart and presentation template.	
<b>QA.1.22.4</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.	
<b>QA.1.22.5</b>	<b>Covid-19 and the impact of Omicron – current and emerging risks</b>	
	<p>KD discussed Covid 19, the variants and particularly the recent impact of Omicron on the organisation.</p> <ul style="list-style-type: none"> <li>• There are currently in excess of one hundred Covid positive patients on the bed base which would appear similar to the peak during the last wave, taking into account the new guidance of counting 10 days, as opposed to the 14 day rule.</li> <li>• The numbers of patients requiring Non-invasive ventilation (NIV), intensive care, or intubation, in this wave of the virus are reduced with very few admissions, to date, requiring intensive care treatment, believed to be due to the vaccine and the vaccine roll out.</li> <li>• Careful monitoring of activity continues, however, a steady decline in numbers is now expected going forward, resulting in a reduction in staff absences and short-term sickness.</li> <li>• As the organisation continues to treat Covid patients, cancer operations, elective cases and other urgent services along with the normal winter pressures continue, for example cardiac and respiratory complaints.</li> <li>• Low staff and patient morale is reported with a return to normality desired.</li> <li>• Risks around staffing were discussed in detail at the People Academy on 26 January 2022 with major increases in harm not currently being identified, for example falls/major fractures, following the tracking of data via the Quality team. Grade 2 pressure ulcers have, however, noted to have increased in December 2021 as well as other low level harms and concerns.</li> <li>• Increase reported in Patient Advice and Liaison Service (PALS) concerns and complaints, from patients, relatives and staff. Further increases are expected over the next three to six months in these areas resulting in an increase in Ombudsman enquiries and with Freedom to Speak Up and whistleblowing concerns also expected.</li> <li>• Due to the wider footprint, sickness absence, long-term sickness absence and the current ways of working, safe levels of care continue to be provided with the opportunity for staff to highlight any concerns. Staff are working exceptionally hard and to the best of their abilities with good personalized care being recorded in records but not necessarily in the prepopulated care plans.</li> </ul> <p>CC noted the impact Omicron has had not only in the community with exponentially high transmission levels, but also reported high levels of transmission within the Trust, with massive operational impacts for the Trust dealing with numerous bay and ward</p>	

	<p>restrictions where bay restrictions currently amount to 17, each episode relating to an unexpected patient identified with Covid following admission. Patient screening continues to take place on admission, however, due to patients being admitted at the early stages of Covid, the virus may not be picked up when swabbing until day 3 or 5. The rapid introduction of changes in Personal Protective Equipment (PPE) guidance continues and the pressures on facilities staff regarding cleaning and decontamination of all wards 24/7 to enable patient flow 24/7 has been a significant challenge to both clinical and facilities staff.</p> <p>LAE noted the difficult situations, different from previous waves of the pandemic, and the additional pressures with the numbers of Covid and non-Covid patients and taking into account staff absences.</p> <p>JH noted that all staff should be proud of their achievements particularly under the recent pressures, noting a recent personal experience of 'kindness' showed to a patient. KD thanked JH for her comment noting the pre-pandemic work by the Patient Experience team on kindness highlighting the fact that staff know good care and the frustrations when the care provided cannot be outstanding. The Non-Executive Directors echoed the comments of JH.</p> <p>KD noted a return to expected standards may take up to 18 months due to future planning considering the increase in the number of surgical beds to enable the recommencement of elective surgery. A recruitment drive for nursing and midwifery staff is usually held annually in September, however, at this time it is not expected sufficient staff will be available to fill all gaps due to increases in the number of wards and the bed base with the current staffing levels.</p> <p>MH noted Risk 3204 from October 2021, regarding reduced staffing levels due to vacancies, sickness and additional capacity having a negative impact on patient experience of care and outcomes due to Covid. KD noted the risk has now been updated, new risk assessments completed and a new risk placed on the Risk Register. Risk 3204 is due to be closed on the Datix system on 31 January 2022.</p> <p>The comprehensive update was welcomed by the Academy.</p>	
<b>QA.1.22.6</b>	<b>Infection Prevention and Control (IPC) Board Assurance Framework (BAF)</b>	
	 <p>QA.1.22.6 - Infection Prevention :</p> <p>CC provided an overview of the highlights within the paper:</p> <ul style="list-style-type: none"> <li>The Covid hospital onset current position was noted with the current 'probable' national definition of hospital onset classified as anyone identified with Covid on or after day 8 of admission. 'Definite' hospital cases are those identified with Covid on or after day 15 of admission.</li> </ul>	

	<ul style="list-style-type: none"> <li>The massive spike in cases in early January 2022 was associated with a large increase in patients being admitted with the new Omicron virus being so transmissible and leading to hospital onset cases as a consequence.</li> </ul> <p>The IPC BAF was revised and published on 24 December 2021. A review was undertaken as noted in the 20 January 2022 paper presented to the Board of Directors which identified the gaps in compliance against the revised BAF:</p> <ul style="list-style-type: none"> <li>Lessons learnt from Covid 19 outbreaks - Limited compliance with patients wearing a mask. The standard required the Trust to provide every assurance that patients are encouraged wherever possible to wear a mask. As a result, a patient Covid 19 awareness pack is being introduced with the assistance of the Patient Experience team, following successful external feedback. This will be adopted at a cost of approximately £0.90 per pack.</li> <li>Staff understand and are adequately trained in safe systems of working including donning and doffing of PPE - Much work has continued over the years including to ensure staff are fit tested where appropriate, however, a formal process as part of mandatory training to provide assurances is being considered with the Learning and Organisational Development team as to how this can be implemented. The IPC team are also working with an international company regarding an innovative Artificial Intelligence product to provide a self-assessment for staff around donning and doffing.</li> <li>Hierarchy of controls risk assessments - The primary action is an evaluation of the ventilation in all areas, including all ward areas.</li> </ul> <p>An outbreak summary of lessons learned over the recent weeks was noted which included the transmission of the virus via visitors. As a result lateral flow testing for visitors was introduced. The lack of adequate ventilation was mitigated with the introduction and encouragement of the use of FFP3 masks within any area where there is a likelihood that staff may be exposed to a positive Covid patient, however, this is not currently national guidance.</p> <p>Improvements, recommendations and assurance areas were discussed:</p> <ul style="list-style-type: none"> <li>The Trust Covid 19 Improvement Programme is based on national, regional and local learning.</li> <li>Recent national initiatives relevant to the IPC BAF are of high priority.</li> <li>Continued screening, triaging and testing throughout the winter period.</li> <li>In-patient isolation periods for Covid 19 cases or contacts reduced from 14 days to 10 days.</li> <li>Occupational Health and Human Resources continue to collaborate with protocols, in line with updated national guidance around periods of isolation announced throughout Covid.</li> <li>Trust Covid outbreaks remain low compared to peers in the</li> </ul>	
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	<p>region.</p> <ul style="list-style-type: none"> <li>• Covid secure workplace risk assessments continue along with high level cleaning and decontamination.</li> <li>• The Trust continues to consider its own risk assessments, experience and lessons learnt to introduce operating procedures which may be ahead of the national guidance when considered appropriate and safe to do so.</li> </ul> <p>MH queried nasal lateral flow testing versus throat swabbing following evidence that the throat swabbing has better detection of Omicron. CC noted the evidence suggesting that lateral flow testing is very positive be it via a nasal or throat swab. The lateral flow test, however, is not as reliable at detecting where a person has no symptoms as the level of the virus shedding, at that time, is not as high as when a person is symptomatic. National evidence now allows for lateral flow testing by staff for returning to work.</p> <p>JH thanked CC for the comprehensive and detailed overview provided to assist staff and patients, noting the patient awareness packs are a very positive idea.</p> <p>MH noted Risk 3540 regarding fit testing, dated October 2020. This high level risk was noted by KD to have received a recent update in the last two weeks and the commentary will be reflected in the next BAF.</p>	
<b>QA.1.22.7</b>	<b>Quality Oversight and Assurance</b>	
<b>QA.1.22.7.1</b>	<b>Quality Oversight and Assurance Profile Serious Incident (SI) Report</b>	
	 <p>QA.1.22.7.1 - Quality Oversight and Assurance Profile</p> <p>LH discussed the presentation in detail describing the learning from the SI reports and the following were highlighted:</p> <ul style="list-style-type: none"> <li>• Seventy complaints have been closed over the last two month period with appropriateness of treatment remaining as the top theme, this being a sub-category of care and treatment.</li> <li>• Increased numbers of contacts reported by the Patient Advice and Liaison Service (PALS).</li> <li>• The number of recorded compliments on Datix has reduced which may be due to clinical staff not having the time to document reported compliments.</li> <li>• There are 14 ongoing SI reports with six having been declared by Bradford Teaching Hospitals NHS Foundation Trust between 15 November 2021 and 16 January 2022, one of which met the criteria for a Never Event. <ul style="list-style-type: none"> <li>○ SI 2021/23948 related to a Healthcare Associated Infection (HCAI)/Infection Control Incident – A Klebsiella infection was detected in the Neonatal Unit. The cases were investigated and specific genotyping demonstrated the cases were of the same genotype demonstrating direct transmission. An outbreak was declared and immediate actions resulted in service disruption as the unit closed to regional admissions.</li> <li>○ SI 2021/24499 concerned suboptimal care of a deteriorating</li> </ul> </li> </ul>	

	<p>patient, where following a recent diagnosis the patient deteriorated rapidly and died. The patient was subject to a Deprivation of Liberty Safeguards (DoLS). The Police Safeguarding team are investigating. Learning has been identified around prompt consultation with other specialities in order to identify differential diagnosis with a number of specialities involved in the patient's care.</p> <ul style="list-style-type: none"> <li>○ SI 2021/25485 – Never Event – Surgical/invasive procedure incident where a chest drain was inserted in to the incorrect side. Learning identified all requirements of the pre-procedure checklist should be completed in all areas of the Trust, with ongoing consent throughout the procedure, ensuring the use of imaging available.</li> <li>○ SI 2021/23585 – A patient developed a Category 4 pressure ulcer to the sacrum. Learning is being taken through the Pressure Ulcer panel and will be shared widely.</li> <li>○ SI 2022/626 – Medication incident. Following prescribed digoxin a patient was diagnosed with a query drug induced bradycardia. The patient subsequently suffered a cardiac arrest, was transferred to the Intensive Care Unit but subsequently died. Learning has been shared which has been really well received by clinical staff with wide dissemination.</li> <li>• Two maternity related incidents were reported, SI 2021/24532 (a neonatal death) and SI 2022/625 (a baby born with no heartrate, resuscitation attempted but unsuccessful), however, in accordance with the requirements of the Healthcare Safety Investigations Branch (HSIB) an independent investigation will be carried out by HSIB.</li> <li>• The 'Bite Sized Learning' regarding Digoxin monitoring and Hydroxyzine medication dispensed instead of Hydralazine tablets, was discussed, produced by the Medicine Safety Lead.</li> </ul> <p>MH noted the great learning and questioned a visit to Pharmacy some time ago when a robot dispenser (albeit an old machine, with a Business Case being prepared) was being used. MH queried what proportion of dispensing is done by machine and whether this was a human error or whether a robot was involved. LH to liaise with Pharmacy.</p> <p>Learning will also be shared with the Scan4Safety Programme team by LH.</p> <p>The improvement programmes in the Trust were discussed, however, it was noted a number of the Quality Improvement team are currently redeployed and local QI work is suspended. The Maternity and Theatre Services Programmes continue. A Transfusion QI programme has commenced to help prevent labelling errors.</p> <p>Assurances were noted and the Trust compliance was highlighted and discussed by the Academy.</p> <p>Externally reportable incidents and the open strategic risks were discussed, the risks requiring review have had reviews requested and are ongoing. The staffing risk and service continuity risk</p>	<p>Senior Quality Governance Lead (LH) QA22000</p> <p>Senior Quality Governance Lead (LH) QA22001</p>
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	<p>assessments are being revisited.</p> <p>There have been no breaches in Duty of Candour since the last report and since August 2016.</p> <p>One SI has been concluded between 15 November 2021 and 16 January 2022:</p> <ul style="list-style-type: none"> <li>SI 2021/15433 – Complications occurred during routine surgery to repair an inguinal hernia in a three year old child which resulted in the requirement for further vascular surgery.</li> </ul> <p>JH queried the seven cancelled clinics affecting 340 women (06/12/2021, WR117461). LAE confirmed this related to first appointments for breast screening, however, all appointments were rearranged with no significant delay.</p> <p>Following discussion the Academy were assured by the immediate actions taken and the comprehensive learning noted.</p> <p>The Academy noted the current position with regards to the on-going SIs and was assured the Trust has processes in place to identify, investigate, improve and learn from SIs.</p>	
	<p><b>High Level Risks relevant to the Academy</b></p> <p>KD discussed the movement log and the risks on the high level risk registers, showing additions, closures and changes in score to the risks. KD referenced the earlier discussions around staffing and the impacts on both staff and patients.</p> <p>The following were highlighted: Two existing risks have decreased to a score of below 15 since the last report and, therefore, no longer appear on the high level risk register:</p> <ul style="list-style-type: none"> <li>Risk 3380 regarding patients with a mental health diagnosis, a high risk due to the numbers of patients admitted where difficulties arose due to staff knowledge/awareness and provision of expert clinical advice. Major work has since been undertaken with the Care Trust and subsequently the Trust has not seen a repeat of this situation. Waits are still, unfortunately, apparent for patients to be seen by Mental Health Practitioners but certainly not as previously experienced due to the close working with the Care Trust.</li> </ul> <p>JP questioned, following the earlier discussion, the potential future mental health situation, following the recent current Covid surge and whether this may exacerbate the situation increasing this risk in the future. KD discussed noting this risk describes patients presenting with the most complex of mental health needs requiring an in-patient admission with lower level mental health conditions dealt with in General Practice. The risk related to patients who may have long-term mental health conditions with sudden acute onset and the acutely unwell, and there being a lack of areas to transfer and nurse these patients in order complex needs are met. Clear pathways are now in</p>	

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	<p>Going forward KD will present to both the People and Quality and Patient Safety Academies the strategic plan for the recruitment and retention of registered nurses and midwives, recruitment avenues and priorities working closely through providers, place and Health Education England. KD is currently in dialogue with the University who have been noted to be failing to attract the required numbers and calibre of candidates. KD will present a Recruitment and Retention plan to the February People Academy.</p> <p>JH raised the issue of the Palliative Care Report (QA.1.22.13), noting the amount of work over the last 18 months by the team, the reporting process and the risk factor and queried whether this should be included on the Risk Register. KD noted this is the Annual Report from July 2020 to July 2021, the data therefore over six months old. The temporary funding issue and the delays in ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) have been resolved. KD will ask Elizabeth Price, Lead Nurse for Palliative Care, to present to the March 2022 Academy regarding the Palliative Care team, recruitment, the ReSPECT agenda and the data presented in the report around the ethnicity of new patients.</p>	<p>Chief Nurse (KD) QA22004</p> <p>Chief Nurse (KD) QA22005</p>
<b>QA.1.22.8</b>	<b>Any Other Business</b>	
	<p><b>Discussion re: Quality Academy Development session:</b> The Academy noted the Development session scheduled for 18 February 2022 had been postponed due to the current operational pressures. A new Development session date will be identified and organised in April 2022 with a pre-planning session.</p>	<p>Associate Director of Governance/ Board Secretary (LP) QA22006</p>
<b>QA.1.22.9</b>	<b>Matters to share with other Academies</b>	
	<p>Workforce/Staffing – A Workforce Board Assurance Framework document will complement the risks and will be submitted to a future meeting of the People Academy.</p>	<p>Chief Nurse (KD) QA22007</p>
<b>QA.1.22.10</b>	<b>Matters to escalate to the Board of Directors</b>	
	<p>Workforce/Staffing – A Workforce Board Assurance Framework document will complement the risks and will be submitted to a future meeting of the Board of Directors.</p>	<p>Chief Nurse (KD) QA22008</p>
	<b>Date and time of next meeting</b>	
	<p>Wednesday, 23 February 2022, 2 pm to 5 pm</p>	
	<b>Annexes for the Quality and Patient Safety Academy</b>	
	<b>Annex 1 – Documents for Information</b>	
<b>QA.1.22.11</b>	<b>Patient Safety Group Highlight Report</b>	
	<p>Noted for information.</p>	
<b>QA.1.22.12</b>	<b>Clinical Outcomes Group Highlight Report</b>	
	<p>Noted for information.</p>	
<b>QA.1.22.13</b>	<b>Palliative Care Team Annual Report – July 2020 to July 2021</b>	
	<p>Noted for information.</p>	

<b>QA.1.22.14</b>	<b>Quality and Patient Safety Academy Structure Chart</b>	
	Noted for information.	
<b>QA.1.22.15</b>	<b>Quality and Patient Safety Academy Work Plan</b>	
	Noted for information.	

### ACTIONS FROM QUALITY ACADEMY – 26 JANUARY 2022

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
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 vaporiser(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. 21.12.21/13.01.22: JC chasing up. 26.01.22: MH has chased up his contact. KD noted duty of Academy is to discharge this duty to the Trust Drug and Therapeutic Committee. This action has been on the action plan since September and the duty was discharged to the Drug and Therapeutic Committee. KD requested clarification. 08.02.22: NHS Team have been asked to follow-up, still awaiting national direction. JC to email David Smith, Director of Pharmacy, to pick up at Drug and Therapeutic Committee. 08.02.22: JC confirmed that issue is being managed by Head of Engineering. Confirmation from D Smith that this item will be added to the Medicine Safety Group agenda. Complete. CLOSED.

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
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 underway around structured judgement reviews and learning from deaths.	Associate Director of Corporate Governance/ Associate Director of Quality	February 2022	16.11.21: LP – To be included on the January 2022 QPS Academy agenda. 21.01.21: Item added to the agenda (JC). 13.01.22: Moved to February 2022 in view of the January meeting being a reduced agenda. 08.02.22: Item on February agenda Q.2.22.9. Complete. CLOSED.
QA21080	24.11.21	QA.11.21.4	<b>Matters Arising</b> <b>Quality and Patient Safety Academy structure chart and presentation template:</b> JC agreed that the Non-Executive Director Champion roles will be identified and listed on this plan when these have been agreed.	Associate Director of Quality	February 2022	08.02.22: Item on February Agenda for information. Complete. CLOSED.
QA21082	24.11.21	QA.11.21.4	<b>Matters Arising</b> <b>Quality and Patient Safety Academy structure chart and presentation template:</b> A final version of the QPS Academy structure chart will be provided in February 2022 when all the acronyms will be written in full.	Associate Director of Quality	February 2022	08.02.22: Item on February Agenda for information. Complete. CLOSED.
QA22000	26.01.22	QA.1.22.7.1	<b>Quality Oversight and Assurance Profile Serious Incident (SI) Report</b> MH noted the great learning and questioned a visit to Pharmacy some time ago when a robot dispenser (albeit an old machine, with a Business Case being prepared) was being used. MH queried what proportion of dispensing is done by machine and whether this was a human error or whether a robot was involved. LH to liaise with Pharmacy.	Senior Quality Governance Lead	February 2022	17.02.22: Abimbola Olusoga, Clinical Pharmacist Team Leader: This incident was due to human error. David Smith, Director of Pharmacy: The majority of the dispensing is undertaken by the robot. If less than a full pack of medicine is dispensed then use manual dispensing as the robot assumes the barcode it is shown is a full pack. The

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						Department could try to put part packs in the robot but we would need to have the technology to create a unique barcode. Complete.
QA22001	26.01.22	QA.1.22.7.1	<b>Quality Oversight and Assurance Profile Serious Incident (SI) Report</b> MH noted the great learning and questioned a visit to Pharmacy some time ago when a robot dispenser (albeit an old machine, with a Business Case being prepared) was being used. MH queried what proportion of dispensing is done by machine and whether this was a human error or whether a robot was involved. Learning will also be shared with the Scan4Safety Programme team by LH.	Senior Quality Governance Lead	February 2022	17.02.22: Learning shared with Scan4Safety Team by LH. Complete. CLOSED.
QA22002	26.01.22	QA.1.22.7.1	<b>High Level Risks Relevant to the Academy</b> MH raised Risk 3468, dated November 2021, requesting an update on staff not following or being able to follow the correct process for recording activity or patient pathway steps on the Electronic Patient Record resulting in incorrect or missing information. KD will discuss with SA to ensure that an update is provided on this risk.	Chief Nurse	February 2022	04.02.22: KD has discussed with Sajid Azeb, Chief Operating Officer, and a briefing note will be provided at the next QPS Academy. 17.02.22: Briefing note provided by SA QA.2.22.20. Complete.
QA22004	26.01.22	QA.1.22.7.1	<b>High Level Risks Relevant to the Academy</b> KD will present a Recruitment and Retention plan to the February People Academy.	Chief Nurse	February 2022	07.02.22: Item requested to be added to the People Academy agenda for 23.02.22. Complete. CLOSED

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QA22006	26.01.22	QA.1.22.8	<b>Discussion re: Quality Academy Development session:</b> The Academy noted the Development session scheduled for 18 February 2022 had been postponed due to the current operational pressures. A new Development session date will be identified and organised in April 2022 with a pre-planning session.	Associate Director of Governance/ Board Secretary	February 2022	
QA22007	26.01.22	QA.1.22.9	<b>Matters to share with other Academies</b> Workforce/Staffing – A Workforce Board Assurance Framework document will complement the risks and will be submitted to a future meeting of the People Academy.	Chief Nurse	February 2022	07.02.22: Item requested to be added to the People Academy agenda for 23.02.22. Complete. CLOSED
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	March 2022	21.12.21: JC to chase up LT. 13.01.22: Moved to March 2022 in view of the January meeting being a reduced agenda. 08.02.22: On February agenda, Q.2.22.7. Complete. CLOSED.
QA22003	26.01.22	QA.1.22.7.1	<b>High Level Risks Relevant to the Academy</b> The difficulties were noted when risks span two Academies and the Executive Director is not a member of the Academy. KD suggested perhaps the Lead Executive should brief their colleagues on their risks prior to the Academy, if a non-attender. KD will discuss with the Lead Director and ask for a position statement for the next meeting.	Chief Nurse	March 2022	



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QA22005	26.01.22	QA.1.22.7.1	<b>High Level Risks Relevant to the Academy</b> KD will ask Elizabeth Price, Lead Nurse for Palliative Care, to present to the March 2022 Academy regarding the Palliative Care team, recruitment, the ReSPECT agenda and the data presented in the report around the ethnicity of new patients.	Chief Nurse	March 2022	28.01.22: Elizabeth Price invited to present at the March 2022 meeting. Item on the March agenda. Complete. CLOSED.
QA22008	26.01.22	QA.1.22.10	<b>Matters to escalate to the Board of Directors</b> Workforce/Staffing – A Workforce Board Assurance Framework document will complement the risks and will be submitted to future meetings of the Board of Directors.	Chief Nurse	March 2022	07.02.22: Item requested to be added to the Board of Directors' agenda for 10.03.22. Complete. CLOSED
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	To be confirmed - April 2022	21.12.21: Item added to the agenda for the Development session on 18 February 2022 (JC). 13.01.22: Development session cancelled due to operational pressures and effects of the pandemic. Further date to be agreed.
QA22009						