Bradford Teaching Hospitals
NHS Foundation Trust

Board of Directors			
Date	**12 May 2022**	**Agenda item:**	**Bo.5.22.12**

Report from the Chair of the Quality and Patient Safety Academy held 27 April 2022

Presented by	Professor Janet Hirst, 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 **27 April 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 27 April 2022	
Previously approved at:	**Committee/Group**	**Date**
	N/A	

Key Matters Discussed

The Quality and Patient Safety Academy met on 27 April 2022. A summary of the key items discussed is presented below. The confirmed minutes from the meeting will be available at Board in July 2022. The next meeting of the Quality and Patient Safety Academy is scheduled for 25 May 2022.

Meeting held 27 April 2022: Key items discussed.

1. Palliative Care (ReSPECT update)

A comprehensive summary of the services provided was warmly received by the Academy. The presentation focussed on the outcomes from the results of the Annual National Cancer Audit for Care at the end of Life (NACEL) and, ReSPECT. Of particular note was the following:

- The approval of a business case to support a 7 day service in line with national recommendations. All staff are now in post.
- Rolling out of the 'last days of life guidance' on the Electronic Patient Record (EPR)
- Improved results seen in a 2021 survey when compared to 2019. With results in the majority of areas above the national summary score in all eleven categories.

The Academy also explored the challenges faced by the service. Key areas discussed included

- Lack of face to face palliative care in the community hospitals.
- Dealing with an increase in the number of referrals which had risen by 40%. The team did aim to see 95% of all referrals on the same day and there has been increased awareness of the service due to the pandemic.
- The team see 45% of all deaths that take place at the BRI and approximately 50% of these have a non-malignant disease and, 41% of that group had suffered from Covid.
- Equity of Access is something that is uppermost on the teams list and there have been positive attempts to improve this position.

It was good to note that the 'End of Life Operational Group' had been relaunched and that monitoring was underway across all areas of the Trust. It was also noted that a new Consultant had been appointed with links to research.

With regard to ReSPECT it was noted that:

- A post had been funded substantively for one day a week for a year and that further funding is to be secured.
- ReSPECT audits are underway with oversight provided by the ReSPECT Steering Group.

- The development of an EPR form is being explored with Cerner but will require support from Calderdale and Huddersfield NHS FT.
- Discussions underway on the sharing of information between primary and secondary care.

The progress made to date was impressive and the Academy looks forward to seeing further improvements in the results particularly with regard to diversity.

2. Clinical Audit High Priority Plan 2022/23

Contractual clinical audits, which form part of the NHS Standard Contract, are expected to be signed off in the next few months. These audits should provide assurance that the Trust is meeting the necessary requirements. There are up to 42 eligible national and local audits (with identified audit leads) reporting in to the Clinical Outcomes Group. The Academy noted that changes being made to the Clinical Business Units structure may bring changes to the governance arrangements. In the past, results of national audits have followed at much later dates. The Trust is working towards the data being available to link with local quality improvement work ensuring that the Trust makes best use of this added intelligence to support the care provided.

3. Standard Operating Procedure for Bradford Accreditation process

In January 2020 all inpatient wards at BTHFT had been rated as part of the Bradford Accreditation Scheme. There were 29 Green and 7 Amber rated wards at that time. The scheme was however paused during the pandemic and is now back on stream. From the learning identified at the time, there are a number of key areas of focus which include:

- Ward leadership, engagement and ownership
- Health care professional focus and inclusion
- Assurance tools in place for ward managers to complete monthly and share with teams to support any improvements
- Assessment standards for unannounced visits reviewed against National and Trust guidance to ensure they can provide assurance of high quality patient care and safety.
- Assessment standards in place for Day Case, Outpatients, ICU, Theatres, Paediatrics and Maternity services and these to be piloted in 2022.
- A 'Chief Nurse panel' implemented for the purposes of assurance, challenge and celebration.

In particular the team expected that these changes would seek to provide clear guidance for ward / department teams on standards expected to deliver safe, effective, high quality care for all our patients, service users and staff.

The Academy is keen to see the outcomes with regard to the ward ratings and to see if this has afforded the opportunity for staff to continually striving for further improvement.

4. Quality Improvement (QI) Programme Update

The Quality team are finalising their work plan to support quality improvement activity across the organisation to ensure full support for the continued development of the quality strategy and the implementation of the Trust's quality governance framework - with 'the patient at the heart and centre'. Areas of learning and improvement are designed to provide assurance with regard to the NHS Patient Safety Framework. The Academy noted the following key areas to be covered.

- The 'Improve as One' challenge (requested by the CEO) to support large and small scale changes with regard to capacity and capability building.
- Delivery of training and development through the QI coaching network,
- Provision of support and learning across the place based partnership.
- Use of internal and external resources e.g.; patients and families, NHS Quest and, facilitated

coaching to support improvements.

The Academy further noted the huge improvements that had taken place following the establishment of the Outstanding Maternity Service programme. The aims for 2022/23 included training and support to be provided by both the Quality Improvement and Organisational Development teams. This work was particularly welcomed by the Academy as it presented an exciting cross-section of a number of the improvement measures and metrics which link to a range of activities.

5. Outstanding Maternity Services (OMS) Programme Update

The key focus of the last eight weeks has been the Maternity EPR Go-live project; a significant change project expected to provide key opportunities for continued change and improvement. Other key items of note discussed were:

- Maternity 15 steps tool used throughout the last year and completed in all areas. This tool has been shared with Airedale NHS FT and the team has participated in their review to assist on their improvement journey.
- Quality Improvement (QI) learning pages have been created and work is now resuming with a focus on key clinical priorities.
- Feasibility work has been completed with regard to the 'building fit for the future' project with the Maternity Assessment Centre (MAC) identified as a priority area.

The Academy echoed its concerns with regard to the MAC, in particular with regard to the privacy and dignity of patients. The service is now running 24 hours, seven days per week. The Academy has noted that the Birmingham Symptom Specific Triage System (BSOTS), used to assess women presenting with unexpected pregnancy related problems or concerns, has been introduced in mitigation. Further, the allocation of a number of clinics is also being reviewed to support this area.

6. Maternity and Neonatal Services Update

In particular the Academy noted the update document and the bi-annual maternity and midwifery staffing paper. The following key items received focussed discussion.

- The two Health Service Investigation Branch (HSIB) reports.
- The second Ockenden report published recently which is being reviewed by the team in detail and there are 15 'immediate and essential' actions noted.
- Focus on Birthrate Plus and the figure identified for safe staffing levels. The current vacancies stand at 7.7 WTE midwives and the team will look at the management of short-term sickness. Staffing numbers however are expected to rise in October.
- Maternity theatre build is almost at handover phase.
- The Cerner/Maternity EPR go live in March 2022 (mentioned under the previous item) has been a success. Any issues identified will continue to be managed and monitored.
- Two data quality midwives have recently been appointed to address concerns with regard to data quality.
- 'Yorkshire Midwives On-Call' production which has provided a positive morale-boost for the unit and the midwifery profession as a whole. The team has been approached nationally to share their learning.
- All the key recommendations have been worked through over the last twelve months with Specialist Midwife roles developed to address them.

The Academy congratulated the team on their work reflected in the programme which provided excellent examples of the service working well. The Academy further focussed on the continuity of care taking account of the latest Ockenden report and the letter from NHS England / Improvement regarding trust actions to be taken where there was a 'significant shortfall of registered midwives'. The Chief Nurse confirmed that the Trust has vacancies running at 35%

which was not considered to be a 'significant shortfall'. This position is expected to change with the appointment of newly qualified midwives in October and, in April 2022 the Trust is expecting to be able to provide full continuity of care.

7. Update on Infection, Prevention and Control (IPC) Board Assurance Framework (BAF)

The IPC BAF reflected all aspect of IPC with a particular focus on Covid. From the report presented the following key items were noted:

- The national percentage of cases diagnosed after day 15 of admission was 13.9%, where regional North East and Yorkshire data was reported as 15.7%.
- Percentage diagnosed at BTHFT 8 days after admission was 9.4% and for day 15 was 14.1% indicating BTHFT is significantly better than the national and regional levels.
- Silver and Gold Clinical Reference Groups and Silver tactical have worked collaboratively to ensure safe patient pathways wherever possible through good screening and isolation protocols and infection prevention strategies.
- The Academy noted the publication of the revised UK Infection Prevention and Control Guidance and an IPC Manual for England on 15 April 2022, which included the stepping down of infection prevention Covid 19 isolation precautions and the stepping down of Covid 19 precautions for exposed patient contacts.

There were gaps in compliance for the revised IPC BAF which included the lessons learnt from Covid outbreaks, staff being trained in safe systems of working and hierarchy of controls risk assessments. The Academy noted that these have been addressed. The Trust Covid Improvement Programme update was noted based on national, regional and local learning. The reduction in restructured bay areas and restricting isolated patients is helping with patient flow; however, close monitoring continues to ensure there are no outbreaks as a consequence. Close liaison continues with the Estates Department which has been essential in mitigating risks throughout the pandemic.

The Academy is fully aware that there has been a huge challenge throughout the last two and a half years however never more so than in the last few months. The speed and scale of change in response to the national guidance has been challenging. Discussions have taken place at Board, at Executive level and at the Gold and Silver Clinical Reference Groups regarding staff and the practices adopted with regard to those contracting the virus as some NHS organisations have changed their rules on attending work where staff test positive for Covid. BTHFT does not feel it appropriate to relax its practices at this stage due to the transmissibility of the new variant. Whilst Omicron is milder in terms of patients requiring intensive care and patients requiring non-invasive ventilation, staff sickness has been a particular issue.

8. Patient Safety Group Highlight Report – April 2022

The areas of work covered by the group during April were discussed with the Academy. The key items of note were;

- Communications to patients, staff and visitors regarding choking and how this risk can be reduced to improve the patient experience around mealtimes.
- Review of an A&E patient story related to communication between all parties including the ambulance service and families.
- Issues regarding the sepsis dashboard and the work being undertaken by the Business Intelligence team to resolve and improve the data.
- The significant work underway to raise awareness of the external management of adolescents with behavioural issues awaiting appropriate placement.
- Work undertaken in relation to the new Patient Safety Incident Response Framework (PSIRF) linked to the national Patient Safety Strategy on Falls Prevention.

- The roll out of high priority training on Patient Safety and Human Factors which is now mandated as part of the National Patient Safety Strategy.

9. Clinical Outcomes Group

The key highlights on assurance, learning and improvement were shared with the Academy. Items covered included the following:

- Framework and reporting structures were now in place with the sub-groups which were now all up and running.
- Improvements in practice around sigmoidoscopy, used in the national screening programme, bringing benefits to patients from a privacy and dignity point of view and, improvements in waiting times
- Reaccreditation of theatre staff.
- The development of the E-Consent Model for EPR and the trials taking place in ENT.
- Easy read patient information leaflets developed for a patient portal.
- The reduction in still births in Maternity.

10. Quality Oversight and Assurance Profile: Complaints, Litigation, Incidents, Patient Experience (CLIP) Report

The Academy was notified that the Patient Safety Incident Response Framework will be introduced in 2023 (part of the National Reporting and Learning System) which should prove more effective than Datix in providing accurate data. There have been issues with regard to Datix which does identify themes correctly however issues have been experienced with regard to data provided in relation to the review and closure of areas. As such a low level of assurance is derived. The Academy noted there is currently no corporate risk on the register with regard to this issue and would like this to be explored. The Academy also commented on the information presented in the report which was quite difficult to digest although the amount of work that has gone into producing the report was recognised. This was a new report and the team has agreed to distil the huge amount of data provided from these areas into one streamlined document. It was also noted that the team might benefit from the provision of a monthly dashboard to reflect learning and improvement.

11. Serious Incident Report

The Academy noted the 12 on-going incidents and their status as documented in the report. The Academy was advised of the four incidents declared during March and April of which three were Never Events. The incidents covered:

- SI 2022/7313 – A fall resulting in a subarachnoid bleed requiring surgery at Leeds Teaching Hospitals.
- SI 2022/6077 – Never Event, misplaced naso-gastric tube.
- SI 2022/7604 – Never Event, ascetic tap performed on wrong patient.

An additional Never Event has occurred which relates to ascetic fluid been taken from the incorrect patient. Investigations are ongoing and the completed reports will be submitted to the Academy.

12. High Level Risk relevant to the Academy

The Academy discussed and noted the following:

- Risk 3761 had been added to the register with an initial score of 15. It related to consultant cover for the Retinopathy of Prematurity service. The Academy was advised that a retired Ophthalmologist will continue to provide sessions post-retirement with colleagues in training to

provide the service. An Advisory Appointments Committee has been held however no appointment has been made. A remote option for the service is now being explored with Airedale NHS FT.

- Risk 3671 had increased in score from 16 to 20 since the last report. This relates to the risk of major or catastrophic harm to patients due to COVID driven operational pressures. The risk had increased to reflect the ongoing pressures faced by the service caused by continuation of COVID and staffing pressures, meaning a combination of downstream bed pressure and significantly reduced medical and nurse staffing within ED and across all hospital wards
- Risk 3489 has been closed since the last report. This relates to 'staff will have a poor experience due to reduced staffing level'. This risk is covered within the overarching staffing risk (3732).
- Risk 3598 There is a risk that Children and Young People admitted to children and adult wards in mental health crisis have variation in their practice/care. This remains an ongoing issue and the key need to find placements for children on discharge. There is work underway with the Local Authority and a new system has been implemented whereby when a child is admitted who is likely to require a specialist long-term placement, a strategy meeting is held on day 5. Continued closer working with children's social care should assist the process.

The Academy confirmed it was assured with the mitigations in place.

13. Quality and Patient Safety Academy Dashboard including update on development of new dashboard

The Academy noted a qualification with regard to the Hospital Standard Mortality Ratio (HSMR) and Summary Hospital Level Mortality Indicator (SHMI) indicators. Both have shown an improved picture with coding issues resolved on the HSMR and the SHMI is now within expected levels. The other key items discussed were:

- Readmissions: This showed a difficult position at present due to elective activity. Data is accurate but is uncertain due to the increase and differences in elective activity. It is expected that this data will become more meaningful during the next six months.
- Pressure ulcers: There continues to be a higher incidence of pressure ulcers compared to previous levels due to the significant use of tight fitting face masks. The increase in Category 3 pressure ulcers are facial ulcers.
- Falls with Harm: Levels remain high due to patients being displaced within the Trust and due to staffing levels. The situation is expected to improve as patients are now being returned back to their usual bed base. The Academy further noted that a targeted piece of work has commenced focussed on Falls within the Trust.
- Mortality structured judgement review (SJRs): This is a new category on the dashboard. 100% of deaths in the Trust continue to be reviewed by the Medical Examiner team up to a month ago however, due to clinicians being deployed elsewhere during the pandemic this has proved difficult to sustain for this period.

Dashboards are under review and it is expected that the new Quality and Patient Safety Academy dashboard will be completed following the Academy development session which will take place in May.

14. Update on Education: Healthcare Professionals in Training – Ensuring a Quality Learning Environment

The Academy received a comprehensive presentation that covered the role played by Health Education England (HEE) and partners working with the Trust to plan, recruit, educate and train the future healthcare workforce. The following key points were highlighted:

- National requirements serving to increase the number of registered healthcare professionals both prior to and during Covid. This has been affected by the numbers leaving the profession during the pandemic. The Trust has increased the number of students at a time when

placement circuits have been most pressurised.
- Improvements described including the balance between workload and learning and the benefits of being in the practice placement area.
- Innovative measures have been developed to help and support learners including new models of coaching, increased supervisor and assessor training provision
- Ongoing monitoring and systems are in place to identify problem areas.
- Student feedback has indicated good learning experiences are being provided, however, recent feedback does indicate there are some issues emerging around workloads and tasks. Action plans have been developed to address these locally in the Trust along with increased monitoring and review of student feedback.

The Academy noted from the report that there is a real opportunity to enhance patient experience, risks and, assurance through the education provision. For further discussions the Academy would also like to understand the educational experience of the workforce as well as students.

15. Research Activity in the Trust

The Academy noted the excellent work underway. The key points from the report include:
- The development of a Trust-wide research dashboard to enable transparency over applied research taking place at the Trust and further, to support patients and staff getting involved.
- The Trust Research Committee has been relaunched and is submitting a £7 million funding bid to assist research supporting patient safety, both in hospital and at home.

The Academy emphasised the importance of a multi-professional organisational collaborative approach with the research team and, wished Bradford Institute of Health Research well for the funding bid.

16. Any Other Business

The Academy was notified that NHS Digital would be switching off NHS mail and MS Teams for users of Windows 10 and wondered if the Trust had any mitigation in place for this. It was agreed that this question would be followed up in the first instance with the Chief Digital and Information Officer and the Associate Medical Director for Informatics.

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 1. Palliative Care (ReSPECT update) and the excellent work taking place
- Item 7. Update on Infection, Prevention and Control (IPC) Board Assurance Framework (BAF); In particular the percentage of patients diagnosed at BTHFT 8 days after admission indicating BTHFT is significantly below the national and regional levels.
- Item 10. Maternity and Neonatal Services Update. In particular the programme 'Yorkshire Midwives on call' which has positively reflected the work of the team.

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

There were no matters to escalate.

Board of Directors			
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New/emerging risks

- One new risk has been added to the risk register for the Quality and Patient Safety Academy; Risk 3761 with a score of 15.

- Regarding item 10. Quality Oversight and Assurance Profile: Complaints, Litigation, Incidents, Patient Experience (CLIP) Report. Of concern are the issues highlighted with regard to Datix and data provided in relation to the review and closure of areas. The Academy has noted there is currently no risk on the register with regard to this issue and would like this to be explored.

Recommendation

The Board is requested to note the discussions and outcomes from the Quality and Patient Safety Academy held on 27 April 2022.