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 30 March 2022

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 **30 March 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 30 March 2022	
Previously approved at:	**Committee/Group**	**Date**
	N/A	

Key Matters Discussed

The Quality and Patient Safety Academy met on 30 March 2022. A summary of the key items discussed is presented below. The confirmed minutes from the meeting held in March are e available at Board in May 2022. The next meeting of the Quality and Patient Safety Academy is scheduled for 27 April 2022.

Meeting held 30 March 2022: Key items discussed.

1. Patient Story: Missed Diabetic Ketoacidosis (DKA) and Sepsis

The Academy received a highly detailed report on a particularly complex case involving a patient known to a number of BTHFT services including the Diabetic Foot Clinic, Renal Clinic and Eye Clinic. The minutes from the Academy meeting detail the actions that took place following the patient's admission to the Accident and Emergency Department (AED) via Yorkshire Ambulance Service (YAS). In summary, the patient attended alone due to COVID-19 restrictions at the time. Concerns raised by the patient's wife recorded on the YAS Electronic Patient Record (EPR) report were overlooked by the AED staff. A plan was made to discharge the patient to the care of the GP for further investigations and, the patient was discharged home with no repeat observations and no awareness that the COVID-19 swab undertaken was positive. The patient was readmitted the following day, with treatment provided immediately for sepsis secondary to COVID-19 pneumonitis and DKA. However, the patient's condition deteriorated over a few days and he sadly passed away, following a wish not to undergo invasive ventilation or CPR.

The Academy discussed in detail the learning from this situation and of particular note is the need to ensure that YAS EPR reports are received and read by clinicians as well as the importance of involving relatives in conversations particularly where we have vulnerable patients. The Academy further discussed the plans to incorporate the YAS ESR reporting into the Trusts EPR system however, there were questions raised with regard to the complexity of this. These concerns were addressed by Paul Southern who provided an explanation on how the EPR system works, as well as highlighting the new systems which would improve visibility.

2. Estates and Facilities Quarterly Service Report

A great deal of work has been undertaken by Estates to improve the maintenance backlog. The Academy was pleased to note the report; in particular reference to improvements made in maternity theatres and the changes made to the ventilation as the risk associated with this could now be removed from the Strategic Risk Register. The Academy also noted that following an unannounced Environmental Health Officer visit

at St Luke's Hospital Catering Facilities, a five star food hygiene rating was awarded. From the report received from Estates, of particular note was reference to the three-year investment programme being developed in the form of a risk based prioritised back-log maintenance programme. The Academy is keen to hear about progress on this during the next quarterly update.

3. Embedding Kindness and Civility

The Academy was in receipt of a comprehensive presentation on the outcomes from a wide range of projects underway. The following highlights were particularly well received.

- The 37 Staff nominations received for the Kindness award.
- 'Kindness' included on the ward accreditation and as part of the Healthcare Assistant new starter induction.
- Increased engagement with other Trusts seeking to learn from BTHFT
- The launch of Kindness Ambassadors at the Kindness and Patient conference in May 2022.
- Ensuring that projects link back to embedding kindness, such as Ageing Without Children.

Work will continue to expand, along with continued engagement across our BTHFT clinical areas.

With regard to progress on Civility, the Academy noted the recent BTHFT staff survey figures on 'staff experience of discrimination, bullying and harassment from patients or service users, an increase in negative comments regarding morale and, feeling undervalued'. This may have been exacerbated during the COVID-19 pandemic as there have been significant changes to the way staff work that can affect workplace relationships. The Trust has developed a toolkit based on the NHSE model, with a focus on culture and respect for staff differences. Two groups, the Civility Project Board and the Civility Advisory Panel, have been established at BTHFT with the aim of improving working life for all staff. The Academy was pleased to note the voluntary staff members of these groups and, the six month work plan developed which reflected a focus on staff wellbeing. The Academy sees this work as invaluable and it is encouraging to learn that staff are given a voice and are utilising it on a number of different platforms.

4. Patient Safety Group

The following learning was highlighted with regard to;

- Three incidents relating to the MRI scanner service regarding metal objects, highlighting some issues with staff responsibilities. This has been reported as a Serious Incident.
- A safety incident within Endoscopy Unit where adrenalin was wrongly administered underlined unclear processes for cross-working between Airedale General Hospital and Bradford Teaching Hospitals.
- A Kiebsiella Outbreak in the Neonatal Unit highlighted reporting delays, issues with the ward environment and Infection Prevention Control protocols.

The Academy discussed the engagement of students in initiatives such as hand hygiene and civility and kindness however, students 'as a transient community' can be difficult to engage, particularly as experienced in recent years with the pandemic. The Academy noted that Medical students are starting to be reintroduced back on to wards in order to positively impact safety and experience for all. The Academy joint chair's agreed that there was a need for a future agenda item to discuss the education of students and, it would be useful for the Academy to understand more about any gaps in education concerning medication related issues. A report has been requested for a future Academy meeting on Medicine Safety, with a focus on 'the learning from incidents and the identification of the risks'.

5. 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 Academy discussed the work of the Quality of Care Panel and their weekly tracking of safety events via; the daily risk huddles, the review of any themes or trends, discussion of Infection Prevention Control measures and, a review of Serious Incidents. The Academy was assured that learning from other safety events is shared widely as well as learning from external sources. The Academy also

discussed the following key items from the reporting:

- Progress with regard to the live QI platform which will be demonstrated at the May Moving to Outstanding meeting.
- The six externally reportable safety events to external bodies.
- Patient Experience Data which showed 50 contacts received in the previous month.
- The 2 new risks that have been added to the risk register in February 2022 for the Quality and Patient Safety Academy:
  - 3748 Planned care risk in relation to Renal Services capacity (current risk score 16).
  - 3753 Planned care risk in relation to increased risk of harm to patients during an MRI under general anaesthetic (current risk score 15).
- The Academy received confirmation that three staffing risks would be combined to create one risk, due to their similarity.

6. Quality and Patient Safety Academy Dashboard

The Academy discussed the content of the dashboard and noted the following key updates:

- Hospital Standardised Mortality Ratio (HSMR) figures and Summary Hospital-level Mortality Indicator (SHMI) - BTHFT lies within expected ranges.
- As a consequence of COVID-19, there has been a fall in readmissions in the last two years due to a fall in elective work and a focus on acute work,
- There has been an increase in Pressure Ulcers over the last two years, with facial pressure sores increasing as result of wearing of facemasks for non-invasive ventilation. It is expected that this number will fall over the coming months.
- Falls with Harm have increased over the last two years, predominantly in the area of elderly care. Reasons for this include staffing numbers and bed-base changes impacting on care.

The Academy discussed the improvements made in 'learning from deaths', particularly in addressing the backlog of Mortality Structured Judgement Reviews (SJRs).
The Academy also discussed in detail the ward changes during the COVID-19 pandemic and how this has impacted the everyday operation of the hospital and its subsequent effect on patient care. It was also noted that, as a consequence of the fall in COVID-19 patients, a number of the changes made are being reverted back to what they were in order to run more efficiently.

7. Care Quality Commission Maternity Survey 2021

The Academy noted that there was an attribution exercise that the Trust Business Intelligence team needed to conduct, however they have experienced a number of issues in uploading on to the portal. It is however anticipated that over the next couple of months the Trusts position will be clearer and the outcomes reported to the Academy.

8. Internal Audit Update

The Academy received a summary of relevant audits completed since the last update received in September 2021 and noted the following along with the assurance level received.

Audit	Assurance Rating
Claims Management (September 2021)	**Significant**
End of Life Care: Patients with Learning Disabilities (October 2021)	**Significant**
Incident Reporting (December 2021)	**Significant**
Hospital Acquired Infections (December 2021)	**Significant**
Patient Safety: Pressure Ulcers (December 2021)	**Significant**
Ockenden Report (January 2022)	**High**
Quality & Patient Safety Academy (January 2022)	**Significant**

Records Management (January 2022)	**Significant**
Consent (January 2022)	**Limited**
Recommended Summary Plan for Care and Treatment (ReSPECT) Process (January 2022)	**Limited**
Harm Free Care: Nutrition & Hydration (January 2022)	**Limited**
CQC Compliance: Maternity (March 2022)	**Significant**

The Academy noted the three that had received limited assurance ratings and that the recommendations agreed were being tracked through the Audit Committee.

9. Infection Prevention and Control Report

From the report presented the following key items were discussed and the actions taken noted:

- The Trust has been identified as a high outlier for MRSA and MSSA infections, therefore there was some work done in this area. The Academy discussed the learning from an MRSA bloodstream infection case and noted that all inpatients were now provided with an antibacterial topical body wash.
- The Trust remains low compared to peers regionally and nationally for C. diff and E. coli.
- Learning as a result of an outbreak of Vancomycin-resistant Enterococcus (VRE) identified in 2021 continued to be implemented. Following a number of improvements this is now closed with an action plan in place to be monitored through the IPCC meetings.

The Academy also noted the report on an outbreak of gentamicin resistant Klebsiella pneumoniae which had occurred on the Neonatal Unit. Observations of practice have taken place and as a result the following have been areas for key actions;

- Ensuring appropriate personal protective equipment,
- Hand hygiene (the overuse of gloves in the pandemic has potentially hindered hand hygiene).
- Cot spacing
- Overuse by staff of high risk equipment (blood gas analyser).

Though there have been no further cases since November and December 2021 and significant improvements have been made. The outbreak remains part of a serious incident investigation with the action plan being monitored through the Clinical Business Unit (CBU) and Trust IPCC meetings.

The Academy did note that COVID-19 received a continuous focus for the Infection Prevention Control team, as well as those challenges presented by an increase in healthcare acquired infections. This though is a position that is also reflected nationally. The Academy recognised that it had been a challenging year to meet objectives for Infection Prevention Control alongside dealing with COVID-19.

10. Any Other Business

The Academy noted that there was no longer a requirement for an external audit to be undertaken for the Trust's Quality Account and that an external audit is not planned for the current year (as agreed at the Audit Committee). The Academy would however consider if it would recommend that an external audit would be required in the future.

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. Patient Story: Missed Diabetic Ketoacidosis (DKA) and Sepsis and the importance of involving relatives in conversations particularly where we have vulnerable patients.
- Item 4. Patient Safety Group and the request for additional reporting on education of students and any gaps concerning medication related issues as well as a report on Medicine Safety, with a focus on 'the learning from incidents and the identification of the risks'.

- Item 8. Internal Audit and the number of significant reports received as well as the High Assurance report on Ockenden.

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.

New/emerging risks

The 2 new risks that have been added to the risk register for the Quality and Patient Safety Academy:

- 3748 Planned care risk in relation to Renal Services capacity (current risk score 16).
- 3753 Planned care risk in relation to increased risk of harm to patients during an MRI under general anaesthetic (current risk score 15).

Recommendation

The Board is requested to note the discussions and outcomes from the Quality and Patient Safety Academy held on 30 March 2022.