

Board of Directors			
Date	14 July 2022	Agenda item:	Bo.7.22.16

Report from the Chair of the Quality and Patient Safety Academy held 25 May 2022

Presented by	Mohammed Hussain, Non-Executive Director, Academy Joint-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 25 May 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 25 May 2022		
Previously approved at:	Committee/Group	Date	
	N/A		
Key Matters Discussed			
The Quality and Patient Safety Academy met on 25 May 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 29 June 2022.			
Meeting held 25 May: Key items discussed.			
1. Service Presentation: Therapies overview; ‘Achilles Tendon Ruptures’			
Physiotherapist, Damian Buck presented a very well received and detailed account of the assurance, learning and improvements related to ‘Achilles Tendon Ruptures’. Actions have led to quality improvements which reflect a better service being delivered to patients through a standardised pathway with good patient recorded outcomes. Examples of service innovation were provided which led into an interesting discussion with regard to encouraging more staff, in particular nurses, to get involved in research and most importantly promoting their involvement in that work.			
2. Clinical Audit Annual Report 2021/22			
A summary of the activity in year on the audit plan for 2021/22 was received, noting that the presentation had also been delivered to the Audit Committee. The full programme was not delivered in 21/22 due to the ongoing national issues with regard to Covid. And an NHSE/I directive to suspend audit work in preference for clinical work. There was a delay in starting until June 2021 and later NHSE/I indicated that ‘whilst data collection was important to support the audit programme, it should not compromise clinical work’ however, the Trust did manage to complete all national audits and national confidential enquiries we were eligible to participate in.			
3. Clinical Audit High Priority Plan 2022/23			
The Academy approved the proposed list subject to the finalised local clinical audits for 2022/23. Improvements to support audits were noted. These included processes for monitoring and oversight of the clinical outcomes programme to see how well we are doing and where further improvements could be made. The Academy further noted that the Quality Governance Framework is due to be implemented in autumn 2022 and the Quality Team is developing an app			

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to support the management of local clinical audits and Quality Improvement Programmes.

4. GIRFT (Getting It Right First Time) Update

A comprehensive overview of the GIRFT programme was presented by the CMOs General Manager, Caroline Varley, who is leading the restart of the programme within the Trust. The national programme is designed to improve the treatment and care of patients; via an in-depth review of services and utilising benchmarking and a data driven-evidence base to support change. The Chief Medical Officer asserted that the evidence is clear that if we work with the information from GIRFT and the Model Hospital we can improve efficiency and productivity with regard to our services. This is not about cost. It is about improving the quality of our services and now it is even more important particularly with the pressures we are experiencing on elective recovery following the pandemic to maximise use of our resources and drive improvements. Work is ongoing with the Director of Finance to ensure that the newly configured Clinical Service Units will have the data they need from a range of sources. Engagement has already been undertaken with the clinical teams, which has been extremely positive. The Academy has been advised that there are proposed plans to discuss developments further at a Board Development session later in the year.

5. Medicines Safety

This presentation was delivered by the recently appointed Medication Safety Officer following a request for further reporting, at the March Academy meeting, to address gaps relating to medicine safety issues. The Academy was assured following the presentation that work is ongoing with teams to ensure that learning is shared with those who need to know. The focus on quality and improvement, learning and assurance was clearly demonstrated with a focus on using data to support the understanding of issues and to drive improvements. The Academy recognised that this had not been an easy task and had taken quite a bit of work to understand our current position. The Academy also noted the methods for sharing learning would be used in other areas, citing the 'Good Catch' newsletters and other bite-sized learning. There were a number of key areas that the Academy would like to be addressed including:

- Medicines reconciliation and ensuring the Trust has the right tools to support this
- Celebrating and promoting the good work from the team widely (both internally and externally)
- Using the Quality and Patient Safety dashboard as a means of assurance

The potential issue of the Omnicell Medicine cabinets was highlighted (and also raised at Open Board in May 2022) with reference to the feedback from other Trusts who had experienced some issues with regard to the integration with Cerner. This has not been seen as a risk on our BTHFT register however the Academy is keen to understand if there are risks to BTHFT and if there are any plans and mitigations in place to address them.

6. Bi-Annual Digital Strategy Update

The Academy noted the report which covered a variety of business lines across teams; investments in the infrastructure, constraints which had been flagged, support provided to ward level staff. This had been a busy six months which had been challenging due to sickness absence however there was a good record of the range of successes (including the implementation of the Maternity EPR) and description of the work in progress that brought benefits to both staff and patients. Future reporting would include reference to the virtual hospital strategy.

7. Safeguarding Adults Annual Report

This comprehensive report provided an overview of the activity within year. The main area of

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future work would include a focus on further development and multi-agency training which the team was keen to progress post-Covid. The team is working with the Education team to develop a training post which would include a focus on de-escalation and conflict resolution in response to the learning from a number of serious incidents.

8. Safeguarding Children Annual Report

The Academy was also in receipt of another comprehensive annual report on the work of the Safeguarding Children team. There has been a lack of growth in staffing compared to the growth in referrals. The issues here have been both of budget and workforce. With regard to the patient profile there have been increasing mental health presentations that are complex issues where children cannot be discharged home. It is expected that referrals to the service will also increase following the imminent publications, including the national review into the murders of Arthur Labinjo-Hughes and Star Hobson. The Academy noted that the Safeguarding Lead will be meeting with the Executives to discuss additional resources that will be required and inform a business case that is being developed which includes additional dedicated staffing.

9. Clinical Outcomes Group

The Academy noted that the key item discussed at the May meeting of the Clinical Outcomes group covered NICE guidance and levels of compliance. Key issues had been noted with regard to overdue items. Whilst it had been a challenging year, compounded by the pandemic, a key focus was on the support required for the Clinical Governance Officers moving forward. Support will be provided from within the core Quality Team. The majority of meetings and forums are back in place and as such the Quality Team has reassured the Academy that it intends to adopt more robust monitoring and oversight to meet the key targets in line with the NHS Standard Contract where 95% compliance is expected with regard to the implementation of NICE guidance and, 100% compliance with regard to 'technology appraisals within 90 days of publication'.

10. Quality Oversight and Assurance

Serious Incident (SI) Report: in summary there were 11 SIs currently being investigated, three of which have also been declared as Never Events.

The Academy noted that:

- One SI had been reported between 18 April and 15 May, which related to a power outage in the Accident and Emergency Department.
- There were four open HSIB (Healthcare Safety Investigation Branch) investigations with two reported in period.

High Level Risk relevant to the Academy: There were two new risks added to the high level risk register:

- 3765 - There is a risk that patients who test positive for COVID-19 (on asymptomatic IP testing) may come to harm due to multiple moves and not being looked after within their specialty, leading to patient harm (delays in treatment, increased LOS, risk of hospital acquired harm deconditioning etc.) – this risk is aligned to the Quality & Patient Safety Academy. It will be reviewed on a regular basis due to the moving situation in relation to the prevalence of COVID-19.
- 3767 - There is a risk that Maternity staff are working within the Bradford community on a daily basis and do not always carry or have access to a lone worker device as per Trust policy – this risk is aligned to the People Academy. Given the potential consequences of this risk on staff safety, ETM agreed that an update would be provided by the Chief Digital & Information Officer at the next ETM meeting on 23 May, to confirm whether this risk could be mitigated

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prior to the current stated target of 30 December 2022.

Since publication of the report, risk 3765 had been closed in response to national guidance. Risk 3767 had been discussed at the People Academy and, the Chief Digital and Information Officer is working to provide devices to support lone workers. There have also been reductions in score for risks 3651, 3711 and 3761 and these will be moved off the register. The Academy is satisfied with the mitigations in place for the Quality and Patient Safety Academy risks.

11. Quality and Patient Safety Academy Dashboard

The Academy noted the development session taking place on 26 May which would include a discussion of the revised indicators in line with the strategic objectives relevant to this academy. In the meantime the Academy noted the following key updates.

- Mortality data. This lies within the expected limits.
- Readmissions. The assertion has always been that the data is uncertain as the Trust is not in 'business as usual mode'. The fall in readmissions is likely to be as a consequence of COVID-19 and reduction in all other activity.
- Category 3 Pressure Ulcers. Pressure Ulcers are below average. We don't currently have Covid patients and so this may be as a result of reduced non-invasive ventilation.
- Falls with harm. Here there is a trend upwards. Wards have been on less staffing numbers than we would like. Further, Elderly care is being delivered in environments not designed for the care of the elderly due to a reconfiguration in relation to Covid. A quality improvement programme for fall preventions will be considered by the Executives shortly. As nurse staffing levels increase we do expect this to have an impact on the levels as well as a move back to the usual environment.

It was requested that a report on Falls with Harm be provided to the Academy within the next few months.

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 the following two items:

4. GIRFT (Getting It Right First Time) Update
5. Medicines Safety

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

There was a question raised with regard to item 4. Medicines Safety and, "The potential issue of the Omnicell Medicine cabinets with reference to the feedback from other Trusts who had experienced some issues in relation to the integration with Cerner. The risks identified pertained to the data to support the integration." This has not been seen as a risk on our BTHFT register however the Academy is keen to understand if there are risks to BTHFT and if there are any plans and mitigations in place to address them.

Recommendation

The Board is requested to note the discussions and outcomes from the Quality and Patient Safety Academy held on 25 May 2022.