Bradford Teaching Hospitals
NHS Foundation Trust

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 29 June 2022

Presented by	Professor Janet Hirst, 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 **29 June 2022**	
Key control	This report is relevant to Strategic Objectives 1: To provide outstanding care for our patients, delivered with kindness and 4: To be a continually learning organisation and recognised as leaders in research, education and innovation	
Action required	To note	
Previously discussed at/ informed by	Quality and Patient Safety Academy meeting held 29 June 2022	
Previously approved at:	**Committee/Group**	**Date**
	N/A	

Key Matters Discussed

The Quality and Patient Safety Academy met on 29 June 2022. A summary of the key items discussed is presented below. The confirmed minutes from the meeting will be available at Board in September 2022. The next meeting of the Quality and Patient Safety Academy is scheduled for 27 July 2022.

Meeting held 29 June: Key items discussed.

1. Estates and Facilities Quarterly Service Report

The Academy received a comprehensive and positive update from the Director of Estates and Facilities on activities underway in relation to Improving the Environment, Governance, Workforce Improvement/Engagement and, Improving and Enhancing Operational EFM Services. Of particular note was the focus on staffing which included 'growing our own' and developments in relation to the appointment of apprenticeships.

2. Urology Serious Incident Report

The Academy received a detailed report on a Serious Incident which involved a male patient who presented at the Haematuria Clinic. The results of the patient's biopsy were not presented at the relevant MDT for discussion which led to treatment options being missed. There are current inefficiencies with regard to the histopathology reporting system which is not presently linked to EPR although this will be remedied later in the year. This affects histopathology and a number of other areas not yet reporting into EPR who have not established effective solutions. The Academy therefore understood that the issue of reporting and disseminating leaning goes beyond the case highlighted. A new specialist team, specifically focussed on the systemic problems identified, has been established which includes the Chief Medical Officer and Deputy Chief Medical Officer. At a later date the Academy will receive an update report from this group on the improvement of processes to be implemented.

3. Managing the risks associated with user training and competency assessment for medical devices

A risk had been identified previously with regard to this area and a report requested to the Academy by the Chief Medical Officer. The presentation provided good assurance with regard to

progress in this area. It was pleasing to note the focus on the wide range of medical equipment staff are required to use, which staff are using it and evidence of their training records. Very often there are risks related to equipment. This is an area of focus for the CQC and it is good to know that BTHFT can now effectively demonstrate that we know what the risks are, know what assets we have and that we can provide assurance with regard to training.

4. Outstanding theatre programme

A comprehensive presentation was delivered which provided background on the learning and improvements being put in place; of particular note was the focus on the 'Golden Patient' and improvements seeking to ensure that patients arrive at theatre on time (noting that a delayed start in theatre has implications for patients, bed capacity, costs and staff morale). This emphasised the need for sharing learning with other teams to support improvements.

5. Nursing and Midwifery Leadership Council – Proposal and Terms of Reference

As part of the Magnet programme, a Nursing and Midwifery Leadership Council has been established. This is in line with the revised BTHFT Nursing and Midwifery Strategy. There are six sub-councils feeding into the leadership council which is inclusive of staff from all levels. The Nursing and Midwifery Council will report regularly to the Academy which approved its terms of reference. The Academy was particularly reassured by the inclusive multi-professional working that the establishment of this Council sought to provide as this had been an issue raised previously.

6. Implementation of New Patient Safety Event Learning Platform

A comprehensive overview was provided on the new Patient Safety Incident Response Framework which provides a new approach to incident management and investigation. The Academy has noted that this framework is borne out of consultation with patients and their families. Due to delays as a result of the pandemic, the framework will be implemented in 2023. BTHFT has been in discussion with colleagues at Leeds Teaching Hospitals NHS Trust who were part of a national pilot to seek to learn from them before the BTHFT formal implementation.

7. Patient Experience Annual Report

The report was taken as read. The Academy has been in receipt of six monthly reports through the year. Of particular note is the increase in complaints in year which was expected as this was the second year of dealing with COVID. As previously requested by the joint chair of the Academy Mohammed Hussain, an additional appendix has been included related to the Parliamentary and Health Service Ombudsman (PHSO) complaints which numbered 10 and only one was partially upheld at the time of reporting.

8. Patient Safety Group Report

In particular the Academy noted the following key items reported on:

- The sharing of learning from Pressure Ulcers improvement across the West Yorkshire Association of Acute Trusts (WYAAT).
- Refocus on sepsis improvement work and links to CQUIN led by the Sepsis nurse and ITU consultant.
- Focussed improvement work on wards with the highest rate of falls. Falls improvement work in line with national guidance.
- Discussion on incorporating patient stories into discussions on learning to provide context and avoid depersonalisation.
- Safer procedures (NatSIPPS) review ongoing to understand where improvements are required.

This was an encouraging report with good examples provided of how we are working with others to learn and improve.

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9. Clinical Outcomes Group

The Academy received a comprehensive summary of the items discussed at the previous meeting. In particular the Academy noted the work underway on e-consent and how, with the support of the Informatics team, this would be implemented across the Trust. The Academy also noted the following:

- Difficulties being experienced with regard to the gathering of data not usually collected with regard to CQUINs.
- Getting it Right First Time (GIRFT) and the focus on deaths amongst patients with learning difficulties and the work with wards to see if improvements were needed to patient care.
- The potential that our Trust may be an outlier for observed deaths for patients who have had an emergency laparotomy. The team has been proactive - identifying the last 10 patients who have died following the procedure - and will conduct systematic judgement reviews to identify any learning.

The Academy noted the report.

10. Quality Oversight and Assurance

The Academy received a broad and comprehensive overview of the current position with regard to oversight and exception reporting. The key information to share is:

Serious Incidents: Supported by thorough and detailed reporting. 7 incidents were identified and declared by the Trust during the last month.

- There are 11 serious incident investigations on-going, 7 of which have extensions to the original deadline in place agreed by Bradford District and Craven Clinical Commissioning Group (CCG). One SI has a “stop the clock” in place as it is subject to a Coronial Police safeguarding investigation.
- There have been no breaches of the duty of candour.

The Academy noted the current position and was assured from the report provided that there is sufficient assurance that the Trust has processes in place to identify, investigate and learn from serious incidents. However, it was noted that the sharing of information across the organisation is an area of focus for the Quality Governance team which is currently working to understand the issues affecting dissemination and to ensure that this is remedied through the new Quality Governance Framework.

High level risks relevant to the Academy: There are two new risks aligned to this academy:

- 3779: There is a risk of the Hysteroscopy service being significantly reduced due to equipment failure. This risk is also aligned to the Finance & Performance Academy
- 3411: There is a significant risk to Oncology service delivery due to two consultant vacancies. This risk is also aligned to the People Academy.

The Academy has noted the risks relating to staffing which remain high. Having taken account of the mitigations the academy did not consider there was anything that needed to be escalated to the Board.

Risk appetite: Following discussion the Academy confirmed it supported the statement presented.

11. Quality and Patient Safety Academy Dashboard

The Academy discussed and noted the following key updates in relation to the dashboard:

- Mortality data. This lies within the expected limits.
- Category 3 Pressure Ulcers. The significant increase seen above the baseline in the previous year is now on the way down. Many were COVID-related which saw an increase in device-related pressure ulcers. However, work is on-going across the system, particularly with Bradford District Care NHS Foundation Trust (BDCT), to better understand this area of work.
- Medicines Reconciliation There are concerns with regard to this area and performance has

dipped as a result of pressures in pharmacy. It is recommended that a deep dive is undertaken and the outcomes reported to the Academy.
- Falls with harm. This continues to trend upwards. The Academy will receive a detailed presentation in September on this area.
- Sepsis: This is showing a slight dip which is good news.

12. Infection Prevention and Control (IPC) Report

The Academy was in receipt of a detailed report. The key items highlighted included the Healthcare equality data report which covered quarter 4.
- The Trust remains an outlier for MRSA/MSSA. A programme of improvements is in place.
- For E Coli and C Difficile, when comparing benchmarked data, the Trust is performing within the middle range.
- With regard to improvement work it has been a challenging year again with COVID and now with the addition of Monkey Pox.
- Quality Improvement methodologies are now rolled out across the Trust and have been published in the Nursing Times.
- A competency booklet has been developed for all link practitioners which was also presented to Yorkshire Trusts at two different conferences. NHSE have adopted the competency booklet across the Yorkshire and Humber area.

The comprehensive summary provided featured great work which the academy considered to be thorough. The Academy accepted the quarterly report.

13. Maternity and Neonatal Services Update

Two key items were highlighted from the suite of documents presented.
- The ATAIN (Avoiding Term Admissions into Neonatal Units) quarterly review which was required to be presented quarterly to meet the Maternity Incentive Scheme requirement. It was reported that the Trust remains consistently lower than the national average for avoiding term admissions into the neonatal unit which was positive news.
- The escalation of a concern made directly to the HSIB (Healthcare Safety Investigation Branch) from the Trust for which the Academy received full documentation and were suitably reassured. There were a number of concerns highlighted which were addressed by maternity services.

The Academy noted the Ockenden regional visit was taking place today (29 June) and so far had elicited positive results. The Academy further heard that with regard to the 2019 CQC action plan, now that the new maternity theatre build had been completed, the issue of ventilation had been addressed. The associated risk was now closed on the risk register. The action plan was also completed and closed.

Items included on the dashboard related to Maternity were discussed. The discussion focussed on the Breastfeeding figures, 3-4 degree tears, Increase in the induction of labour and, Stillbirths. It was concluded by the Academy that there is more learning and attention to be paid to all of these issues until we are assured that the assumptions stated come to fruition. Having anticipated outcomes based on the population we provide for [health and social demographics], and accepting them as the correct figures to use for benchmarking, our data is not yet reassuring if we are progressing towards the provision of an Outstanding Maternity Service.

14. Quality Account 2021/22

The Academy received the final version of the document that had been signed off by the Board of Directors in June. The Quality Account 2021/22 had now been published on the Trust website and on the NHS Choices website - as such all regulatory obligations had been met. The Academy agreed that it would receive quarterly reports pertaining to the priorities for improvement identified

for 2022/23 in year.

15. Feedback from Quality and Patient Safety Academy Development Session/Proposed amendments to Terms of Reference

The Academy noted the overall good feedback received from the session and noted the further work to be done outside of the meeting and that actions from the development session will flow through to future meetings. The changes to the Terms of Reference were agreed. These covered the expected level of attendance by members of the Academy of 70% and clarity on the academy role around considering the BAF and the high level risks in line with the new risk management strategy.

16. Research Activity in the Trust

This report was received and noted. It was encouraging to see all the preparations underway for staff to maintain an interest in research and develop their critical appraisal skills - evidenced by the number of PhDs, doctoral training and applied health research feeding into work streams.

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:

2. Urology Serious Incident Report. The Academy is keen to hear further of the work of the specially convened group on the improvement processes to be implemented.
5. Nursing and Midwifery Leadership Council – Proposal and Terms of Reference. The Academy is keen to see this new governance model flourish, in particular with the involvement of staff at all levels.

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

The new Patient Safety Incident Response Framework includes the requirement for Boards to now sign off Patient Safety Incident Investigations (SSIs). The Associate Director of Quality has suggested that a session is scheduled with the Board to advise further of the requirements.

New/emerging risks

There were no new risks arising from the meeting.

Recommendation

The Board is requested to note the discussions and outcomes from the Quality and Patient Safety Academy held on 29 June 2022.