Board of Directors			
Date	**22 September 2022**	**Agenda item:**	**Bo.9.22.13**

Report from the Chair of the Quality and Patient Safety Academy held 27 July 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 **27 July 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 27 July 2022	
Previously approved at:	**Committee/Group**	**Date**
	N/A	

Key Matters Discussed

A summary of the key items discussed at the meeting held in July is presented below. The confirmed minutes from the meeting will be available at Board in November 2022. The next meeting of the Quality and Patient Safety Academy is scheduled for 28 September 2022.

Overview of meeting held 27 July 2022

The Academy welcomed Gill Paxton, Associate Director of Quality & Nursing, Bradford District & Craven Health and Care Partnership, who is now a standing invitee to Academy meetings. This is in line with the Trust's new partnership arrangements which commenced on 1 July 2022.

Key items discussed

1. Quarterly Oversight and Assurance Exception Profile

The Academy received a broad and comprehensive overview of the position since the previous Academy meeting which was further supported by detailed additional reporting. Key areas of focus included:

- Safety events: Where the key themes and trends identified were 'continuing pressures within the emergency department' and, 'laboratory results not being followed up'.
- Serious Incidents (SIs): 1 had been declared during the reporting period and 1 had been closed. There were currently 19 ongoing SIs - 6 of which are subject to independent investigation by the Healthcare Safety Investigation Branch.

There was a good and thorough discussion on staff learning from incidents and how the Quality Improvement team is working to ensure this is embedded and sustained.

High Level Risks. The Academy noted the reduction of score in a number of the risks however particularly focus was placed on:

- Risk 3779: the Hysteroscopy service being significantly reduced due to equipment failure; the score had reduced and a good discussion was held at the F&P Academy (to which this risk is also aligned).
- Risk 3792: Cerner and the Maternity EPR. The Academy noted the mitigations in place to ensure appropriate discharge data are collected. However, there are a number of issues that

have become manifest since the recent implementation of the Cerner EPR. A 'digital quality summit' has been established to maintain oversight, put in place mitigations and ensure that the service remains safe whilst the issues are addressed. Risk 3792 will therefore be absorbed into a broader 'digital maternity risk' to encompass all issues being addressed.

2. Quality and Patient Safety Academy Dashboard

Work is progressing with the development of the dashboard as new metrics have been added. Many of the metrics provided showed expected or improving positions. In particular, I would like to highlight the discussion held by the Academy on 'learning from deaths' and 'end of life care' and the importance of making the last hours/days/weeks of a patient's life as pain free and comfortable as possible - thus giving patients and their relatives something positive out of a painful outcome. It was good to note tailored changes in care in recognition of the needs and experience of the dying patient and their family, and the need to care and prepare people appropriately and respectfully. These were also factors considered within the structured judgement reviews (SJRs). It was noted that some experiences had not been positive and there is opportunity for all staff to learn and develop practice to enable outcomes to be as good as possible for the patient and for their relatives. The Academy recognises that when things go well, care of the dying patient and their family is something to be proud of and should be recognised as such. In addition, learning from other dimensions is equally important when we have not got it right.

3. Claims, Litigation, Incidents and Patient Experience (CLIP) Report

This report has been reinstated post-pandemic, providing a view of our Trust 'in the round'. There is further work to be done with regard to triangulation however; at the present time the top themes are 'safety events related to staffing', 'delays in prescribing of critical medications' and, 'patients with mental health needs'. The Academy noted the report would benefit from some balance brought by an added focus on compliments received. The Quality Improvement team is investigating how best to include these recognising that they can support best practice.

4. Infection Prevention and Control Board Assurance Framework

The Academy discussed the challenges with regard to encouraging all patients to wear face masks in clinical areas (and at the hospital in general) - in contrast to national guidance. It was good to note that staff are being supported by the IPC team, clinical teams and matrons to ensure that the majority of patients are able to comply.

The Academy was further advised that the flu season is predicted to start earlier than usual and the flu vaccine developed is considered to be highly efficient. With regard to winter pressures more inpatients than usual are expected as a result of other respiratory conditions and this is a cause for concern. The IPC team has a good track record with regard to horizon scanning in this area and the Academy is reassured that it will be as prepared as it can be however; the Academy is concerned about the upcoming winter pressures.

5. Bradford Insight Quality Review Datapack

The nationally produced data pack (for BTHFT) describes the range of performance indicators that regulators and commissioners use to provide oversight on the performance of our Trust. It was noted that the information had been shared with the Executives and also with each of the Academies. The Academy was reassured that issues around data accuracy are being considered and, that reporting on the different elements takes place within the organisation. The Academy noted the discussions taking place at the System Quality Committee with a view to developing

uniform dashboards using common metrics for the partner organisations. The Academy is keen to see the agreed metrics later in the year.

6. Progress update from Quality and Patient Safety Academy Development Session

A good, thorough and transparent discussion was held on the outcomes from the development session held in May which covered the pros and cons regarding content and the structure of the meetings. The Academy held a particularly frank discussion on how members and attendees approach each meeting of the Academy. This covered the papers presented, the use of presentations, level of expert / non-expert knowledge and the effective use of time. Further to this discussion proposals regarding the necessary changes will be brought back to the October meeting for approval and implementation. Of particular note is that the Academy members are in favour of creative solutions to enable the Academy to focus on assurance, learning and improvement.

7. Maternity and Neonatal Presentation (including quarterly update from the Outstanding Maternity Services Programme)

A high-level overview of progress to date was received providing 'a spotlight' on Maternity. This was a very useful report covering the journey that has been made since the 'required improvement ratings' from the CQC inspections in 2018 and 2019. The Academy applauds the entire team on the journey made.

8. Mortality Review Improvement Programme/Learning from Deaths Quarterly Update

This was an excellent report and the assurance provided was high. Key to note was that 81% of the Structured Judgement Reviews (spoken of earlier in the meeting) found that overall care given to patients prior to death was graded as adequate to excellent. The Academy heard about the plans for improvement and noted that, whilst the information presented under SHMI (standardised hospital mortality ratio) and HSMR (hospital-level mortality indicator) under the dashboard item referenced learning from deaths, this report considered the learning from the wider not just from our organisation but also from the wider coronial system. This is not something that the Trust had access to previously. Engagement from amongst clinicians has been particularly good primarily because of the evidence provided in relation to patient care. This serves to support the organisation in learning from areas where we have not done well and from the areas where we have done well. A commendable report.

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:

6. Progress update from Quality and Patient Safety Academy Development Session. This was an important and very beneficial discussion. It bodes well for the development of the Academy to ensure that we meet our remit and, seek to ensure that attendees and members get the most out of their involvement in the Academy. I am pleased also that we considered how to engage with our wider staff group, patients and the public.
8. Mortality Review Improvement Programme/Learning from Deaths Quarterly Update. This first quarterly report has provided good assurance to the Academy on how this supports learning from deaths to better provide good, safe and dignified care to our patients at end of life.

The Academy is also assured that the risks recorded on the Risk Register are appropriate in the

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context of the information presented, and are being managed appropriately.

Matters escalated to the Academies or Board of Directors for consideration

The Finance and Performance Academy to be advised of a request from the 'System Quality Committee' on whether BTHFT collects data with regard to 'harms which can be attributable to system pressures' – to support discussions and review at the system level.

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 27 July 2022.