

# QUALITY AND PATIENT SAFETY (QPS) ACADEMY MINUTES

<b>Date:</b>	Wednesday, 30 November 2022	<b>Time:</b>	14:00-16:30
<b>Venue:</b>	Microsoft Teams meeting	<b>Chair:</b>	Mr Mohammed Hussain (MH), Non-Executive Director/Joint Chair
<b>Present:</b>	<p><b>Non-Executive Directors:</b></p> <ul style="list-style-type: none"> <li>- Professor Janet Hirst (JH), Non-Executive Director/Joint Chair</li> <li>- Mr Mohammed Hussain (MH), Non-Executive Director</li> <li>- Mr Altaf Sadique (AS), Non-Executive Director</li> <li>- Ms Sughra Nazir (SN), Non-Executive Director</li> </ul> <p><b>Executive Directors:</b></p> <ul style="list-style-type: none"> <li>- Dr Ray Smith (RS), Chief Medical Officer</li> <li>- Professor Karen Dawber (KD), Chief Nurse</li> <li>- Dr Paul Rice (PR), Chief Digital and Information Officer</li> </ul>		
<b>Members:</b>	<ul style="list-style-type: none"> <li>- Mr John Bolton (JB), Deputy Chief Medical Officer/Operations Medical Director</li> <li>- Dr Paul Southern (PSO), Consultant Hepatologist/Associate Medical Director</li> <li>- Dr Padma Munjuluri (PM), Consultant Obstetrician and Gynaecologist/Associate Medical Director</li> <li>- Dr Harry Ashurst (HA), Consultant Anaesthetist/Lead Medical Examiner</li> <li>- Dr David Robinson (DR), Director of Education/Consultant in Emergency Medicine</li> <li>- Dr Michael McCooe (MM), Consultant in Anaesthesia/Associate Medical Director</li> <li>- Ms Amanda Hudson (AH), Head of Education</li> <li>- Mrs Sally Scales (SS), Director of Nursing</li> <li>- Mrs Karen Bentley (KB), Assistant Chief Nurse</li> <li>- Mr Kez Hayat (KH), Head of Equality, Diversity and Inclusion</li> <li>- Ms Judith Connor (JC), Associate Director of Quality</li> <li>- Ms Liz Tomlin (LT), Head of Quality Improvement and Clinical Outcomes</li> <li>- Mrs Adele Hartley-Spencer (AHS), Director of Nursing</li> <li>- Mrs Sara Hollins (SH), Director of Midwifery</li> <li>- Mr David Smith (DS), Director of Pharmacy</li> <li>- Mrs Joanne Hilton (JHi), Deputy Chief Nurse</li> <li>- Ms Caroline Varley (CV), General Manager, Chief Medical Officer's Office</li> <li>- Ms Laura Parsons (LP), Associate Director of Corporate Governance/Board Secretary</li> <li>- Dr Yaseen Muhammad (YM), Nurse Consultant/Director of Infection, Prevention and Control</li> <li>- Ms Jill Clayton (JCI), Deputy Director of Nursing</li> <li>- Ms Joanna Stedman (JS), Deputy Director of Nursing</li> <li>- Ms Kelly Young (KY), Deputy Director of Nursing</li> <li>- Ms Leah Richardson (LR), Patient Safety Specialist</li> <li>- Ms Marianne Downey (MD), Deputy Director of Nursing</li> </ul>		

<b>Attendees</b>	<ul style="list-style-type: none"> <li>- Ms Gill Paxton (GP), Associate Director of Nursing and Quality, Bradford District and Craven Health and Care Partnership</li> <li>- Ms Jacqui Maurice (JM), Head of Corporate Governance</li> </ul>
<b>In Attendance</b>	<ul style="list-style-type: none"> <li>- Mr Nick Rushton (NR), Patient Safety Manager, in attendance for agenda item QA.11.22.10.1</li> <li>- Mr John Holden (JHo), Director of Strategy and Integration, in attendance for agenda item QA.11.22.12.</li> <li>- Ms J Kitching, Minute-taker</li> </ul>
<b>Observers</b>	<ul style="list-style-type: none"> <li>- Ms Ruth Dunlop, Non-Executive Director Insight Placement</li> </ul>

MH welcomed SN to her first meeting of the Academy in her capacity as Non-Executive Director.

<b>Agenda Ref</b>	<b>Agenda Item</b>	<b>Actions</b>
<b>QA.11.22.1</b>	<b>Apologies for Absence</b>	
	<ul style="list-style-type: none"> <li>- Mr Jon Prashar (JP), Non-Executive Director</li> <li>- Dr LeeAnne Elliott (LAE), Deputy Chief Medical Officer</li> <li>- Ms Sarah Wood (SW), Quality Lead, Nursing and Midwifery</li> <li>- Mrs Sarah Freeman (SF), Director of Nursing</li> <li>- Ms Jane Kingsley (JK), Lead Allied Health Professional</li> <li>- Mrs Kay Rushforth (KR), Head of Nursing, Children's Services</li> </ul>	
<b>QA.11.22.2</b>	<b>Declarations of Interest</b>	
	There were no declarations of interest.	
<b>QA.11.22.3</b>	<b>Minutes of the meeting held on 26 October 2022</b>	
	<p>The minutes of the meeting held on 26 October 2022 were approved.</p> <p>The Academy noted that the following actions had been concluded:  QA22046 – QA.9.22.15 (28.09.22) – Matters to Share with Other Academies – Patient Discharge.  QA22047 – QA.9.22.19 (28.09.22) – Introduction of New Clinical Procedures or Techniques Policy.  QA22048 – QA.10.22.5 (26.10.22) – Quality Oversight and Assurance Profile.  QA22049 – QA10.22.5 (26.10.22) – Quality Oversight and Assurance Profile.  QA22052 – QA.10.22.5 (26.10.22) – Quality Oversight and Assurance Profile.  QA22053 – QA.10.22.5 (26.10.22) - Quality Oversight and Assurance Profile.</p>	
<b>QA.11.22.4</b>	<b>Matters Arising</b>	
	There were no matters arising from the Minutes that were not already on the agenda. Verbal updates were given at the meeting on the outstanding and closed actions and these were reflected in the action log.	
<b>QA.11.22.5</b>	<b>Quality Strategy (including update on Patient Safety Incident Response Framework (PSIRF))</b>	
	JC presented an overview of the initial draft of the Quality Strategy	

	<p>which requires further updates from a number of areas. This is a shared single view of quality with high-quality, personalised and equitable care, ensuring those working in systems deliver care that is safe, effective, responsive and personalised, caring, well-led and sustainably-resourced. The Strategy is based on the national work from the National Quality Board, Health Foundation and the National Patient Safety Strategy and will ensure the Trust is future-proofed, aligned to the organisations, place and the Integrated Care Systems (ICS) priorities. The benefits were described around enhancing the patient experience, improving population health, reducing costs and improving provider work life.</p> <p>The Health Foundation paper recently published supports the Patient Safety Incident Response Framework (PSIRF) to assist healthcare organisations to examine serious incidents without fear of inappropriate sanctions while supporting people affected, with the ultimate aim of improving services by focusing on patient safety.</p> <p>The patient safety incident response standards were noted:</p> <ul style="list-style-type: none"> <li>• Policy, planning and oversight.</li> <li>• Competence and capacity.</li> <li>• Engagement and involvement of those affected by patient safety incidents.</li> <li>• Proportionate responses.</li> </ul> <p>The Strategy will demonstrate that learning is at the heart of the Trusts approach to quality. Further engagement is required with colleagues across the organisation, to ensure that it is aligned to the Trust's Strategy and integrated into other strategies including the Corporate Strategy.</p> <p>LR provided the PSIRF update highlighting the move to diagnostics and the discovery/recovery phase of the project plan noting the close working with the Bradford Institute for Health Research (BIHR). A training needs analysis has been developed around PSIRF and the wider teams to identify the skills required. A communication plan is being considered along with engagement with stakeholders.</p> <p>KD provided the Academy with assurances around the monthly Moving To Outstanding (M2O) meeting and the mapping work underway ensuring the Trust is fully sighted on the areas of quality required for the Care Quality Commission (CQC). An M2O lead has recently been appointed to begin gathering evidence from a compliance perspective for this ongoing process/journey.</p> <p>JC noted the continued engagement with KH around inequalities, a feature of both the Quality and Trust strategies and highlighted there cannot be quality improvement without Equality, Diversity and Inclusion (EDI).</p>	
<b>QA.11.22.6</b>	<b>Quality Account – Progress Update</b>	
	LT described the purpose of the Trust's Quality Account to increase public accountability and driving improvement in the organisation,	

	<p>and the four priorities in this year's account were noted:</p> <ol style="list-style-type: none"> <li>1 - Improving the management of deteriorating patients.</li> <li>2 - Improving the patient experience.</li> <li>3 - Continued reduction in stillbirths.</li> <li>4 - Advancing equality, diversity and inclusion (EDI) within the organisation.</li> </ol> <p>An update on priorities 1 and 4 were provided and the actions underway concerning each priority noted.</p> <p>Priority 1:</p> <ul style="list-style-type: none"> <li>• Further work regarding the managing and monitoring of sepsis. PSo provided assurance on all the work undertaken in the Trust over the last five years with regards to sepsis noting the frustrations around the sepsis alert, due to algorithms, and that these issues remain high on the Trust's agenda to resolve. PSo agreed to provide data to benchmark the Trust against other Cerner Trusts regarding sepsis screening and Time to Treat.</li> <li>• Challenging issues regarding Cerner Maternity currently being addressed, resulting in changes in trends to the statistics presented.</li> <li>• Successful NHS England bid for the Trust to partake in a Worries and Concern Pilot being the only Trust invited in the region. This funding will support patient and public involvement activities including the involvement of patients, carers and families with worries/concerns when patients become unwell. BIHR colleagues are linked to this project.</li> <li>• The Care Quality Commission (CQC) action plan is being kept up-to-date to reflect the steps required for the additional ongoing work in Maternity around Cerner.</li> </ul> <p>KH presented information regarding Priority 4, demonstrating the focus on key priorities in terms of the workforce inequalities and health inequalities. An Equality and Diversity Council has been set up to identify the priorities for the Trust in terms of tackling some key health inequalities. The target of 35% of Trust employees being of a diverse workforce has been achieved. A reciprocal mentoring scheme has been rolled out.</p> <p>A wider focus of work around embedding and mainstreaming EDI across the Trust has been an evidence-based approach with work around workforce/race equality and workforce disability equality and results are evident.</p> <p>A dedicated EDI strategy is under development, an enabling strategy of the Corporate Strategy.</p> <p>The five key objectives under consideration as equality objectives as part of the EDI Strategy were highlighted:</p> <ol style="list-style-type: none"> <li>1 – Education, empowerment and support.</li> <li>2 – Effective community and staff engagement.</li> <li>3 – Population health inequalities.</li> <li>4 – Promoting inclusive behaviours.</li> <li>5 – Reflective and diverse workforce.</li> </ol>	<p>QA22056 Associate Medical Director (PSO)</p>
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	<p>This work is being linked to the Engagement Strategy under development by Patient Experience with an aim to focus on the reflective and diverse workforce at all levels and embed the infrastructure in these key areas of day to day practice.</p>	
<b>QA.11.22.7</b>	<b>Serious Incident (SI) – Focus on Learning</b>	
	<p>KD discussed the SI learning with the Academy with regards to two cases:</p> <p>Case 1 - Learning from safety events – unexpected birth on the Children’s Unit.</p> <p>Case 2 - Resuscitation – Red Border email.</p> <p>KD shared the two examples of how immediate learning had been disseminated very quickly via an email and a red border email, noting learning is not reliant just on the final SI report but can be implemented as and when necessary.</p> <p>Case 1: Communication was immediate, clear and to the point, detailing what had occurred and how the learning from this, and the issued document as part of the Clinical Specialty Unit’s (CSU) weekly learning email.</p> <p>Case 2: The red border email was an immediate reminder to staff in the event of an unexpected collapse or cardiac arrest with resuscitation being commenced prior to Do Not Attempt Cardiopulmonary Resuscitation (DNA CPR) status being verified either from positive affirmation from handover or confirmation via Electronic Patient Record (EPR). KD noted this status should not be pre-populated on printed handover sheets and was issued as a reminder to all staff on how to check a patients Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) status. This case also highlighted the work of the Virtual Royal Infirmary noting the importance to ensure equitable access to this facility.</p> <p>Following discussion of the cases the first had demonstrated rapid learning with the second demonstrated a conclusion completely different to the expected conclusion.</p> <p>JCI discussed case 2 where the patient had multifactorial presentations, had no next of kin and no one to identify that there was something very wrong following the patient’s distinct deterioration.</p> <p>A conversation ensued around previous difficulties having been raised recently and difficulties noted with the Cerner system regarding the logging of forms and facilities for flagging on the system and whether the earlier issues had been rectified. KD noted a patient’s DNACPR status is logged on the EPR. Advanced decision forms for example, Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) and End of Life care plans may not be identified on the system as these are currently paper-based forms. A flag, however, can be added. PSo noted the amount of recording required behind the DNACPR form and at the time of installation of the Trust’s EPR, this was gold standard. ReSPECT has since followed with this form not belonging to an</p>	

	<p>organisation but to the patient and that not every organisation has access to a digital system that allows access to this information. This is a patient focused broader piece of work with ReSPECT concerning the defining and sharing of a patient's wishes with all patient carers.</p> <p>PSO noted conversations on this complex piece of work continue at both regional and national level, particularly the sharing of ReSPECT forms through care records regionally.</p> <p>JH expressed both reassurance and assurance at the willingness, openness and transparency of the cases shared and the inspiration demonstrated through these communications as training tools.</p>	
<b>QA.11.22.8</b> <b>QA.11.22.8.1</b>	<b>Learning from Maternity Health and Safety Investigation Branch (HSIB) Reports</b>	
	<p>SH provided a summary of the Healthcare Safety Investigation Branch (HSIB) cases since referrals commenced approximately two years ago. There have been a total of 43 referrals submitted to the HSIB portal since its inception. Of 43 referrals, 18 have been rejected for a number of reasons, for example, non-engagement or not meeting the set criteria.</p> <p>Total investigations submitted to date stand at 25, with 19 now completed. Investigations are returned within a six month period. Six cases currently remain active. There have been no exception reports within the cases submitted, there have been two maternal deaths.</p> <p>The top recommendations for Quarter 1 2019/20 onwards were discussed and the themes, trends and recommendations noted.</p> <p>Assurance was provided to the Academy that information and engagement from HSIB are discussed on a regular basis.</p> <p>A quarterly review meeting is held with the HSIB team to discuss national HSIB data which is compared to the Trust's investigations/data. This then feeds into the local, regional and national Perinatal Quality Surveillance Oversight Groups with actions monitored through the Women's Core Governance Group on a monthly basis. Completed audits relating to HSIB cases are discussed at specialty meetings.</p> <p>SH noted in relation to the receipt of the concluded investigations from HSIB, the Trust has no control, however, an immediate 72 hour review of all cases is undertaken within Maternity and any immediate learning implemented. HSIB have rarely highlighted anything significantly different to that identified by the Trust at the immediate review. Recommendations received from HSIB can often be closed immediately on receipt.</p> <p>KD reminded the Academy that a thoroughly concise report is already received bi-monthly of new SIs, those closed, delogged, the content, immediate learning identified when the report is closed</p>	



	<p>and any delays to reports are highlighted.</p> <p>It was agreed that full SI reports will now be attached and included in the SI report.</p> <p>The immediate learning, reviews and agility of this report was noted. SH noted previous challenging meetings held with HSIB, however, the Trust has a good relationship with HSIB in a learning environment. Separate meetings have been held by the Trust with HSIB and processes are now in place for the Trust to provide any assurance or responses to any concerns by HSIB.</p> <p>The current national picture of Maternity was highlighted with the Academy assured all Trusts are working on the same suite of challenges.</p> <p>JC described, as part of the Quality Strategy and PSIRF work, an alignment report is being considered to circulate any immediate learning and which will be appended to the investigation reports.</p> <p>The Academy noted the SI report does not demonstrate learning, it is a summary of how the investigation is conducted with the learning and the actions taken to prevent such an incident occurring again.</p> <p>GP raised the Quality Oversight process of SIs through the Integrated Care Board where supportive conversations and professional challenge around quality oversight continues. Meetings are held with Airedale and Bradford together to look at system challenges and of areas to note moving forward to support the Trust. This is useful both collaboratively and for the patient experience.</p>	QA22057 Associate Director of Quality
<b>QA.11.22.8.2</b>	<b>Outstanding Maternity Services (OMS) Programme</b>	
	The item was taken as read by the Academy.	
<b>QA.11.22.9 QA.11.22.9.1</b>	<b>Patient Experience (PE) Six Monthly Report</b>	
	<p>KB discussed the Patient Experience (PE) report providing a six monthly update (Quarter 1 and Quarter 2 activity) on the work that has taken place in relation to PE noting the workstreams that feed into the PE group. The monthly PE updated was attached at QA.11.22.21.</p> <p>The following areas of work were highlighted:</p> <ul style="list-style-type: none"> <li>• Constant consideration of ways to improve the patient experience.</li> <li>• Important links to patient safety.</li> <li>• Identifying risks.</li> <li>• Engagement work allowing teams to seek opinions of those working in the community.</li> <li>• Embedding kindness project.</li> <li>• Carer work has continued and a Carer policy developed to support the work on the Carer plan and Carer passport.</li> </ul>	

	<ul style="list-style-type: none"> <li>• SPaRC services (chaplaincy) have received national recognition and awards.</li> <li>• Partnership working continues with Healthwatch.</li> <li>• Complaints, Patient Advice and Liaison Service (PALS) and compliments data summarises the learning that has occurred. Detailed analysis of complaints where local resolution has not been agreed and the complainants have taken their case to the Parliamentary Health Service Ombudsman.</li> <li>• Patient Stories - Vitrally important for learning.</li> <li>• Numerous ways that the team and service demonstrates learning.</li> </ul> <p>The improvement work in the last quarter was particularly noted around the new Carer policy, passport and charter which now includes young carers. It was agreed that the reference on the Unpaid carer care plan and agreement, 'feeding' would be amended to 'managing nutrition' in order to be more dignified and inclusive.</p> <p>The themes emerging from the Accident and Emergency Department survey, particularly the concern of rude staff, being unacceptable behaviour, was highlighted. KB noted the customer service type training and work around civility and incivility which is underway and training on kindness continues. Mechanisms are in place in order examples of rudeness can be addressed quickly by a senior member of staff. Psychology colleagues have also provided sessions to the Accident and Emergency Department team as a means of supporting their responsibilities. Individual support/guidance is also available to all staff acknowledging lives outside work.</p> <p>KB noted the difficulties sometimes experienced in retrieving information from the Trust's Datix system, due to limitations as how best to represent data. There have been previous discussions about how data could be improved as a large amount of data was reflected as "other". KB took as an action to revisit this again, to discuss and consider any options that would provide more meaningful data to this cluster. This system may be upgraded in time. Trust systems should, however, function fully.</p>	<p>QA22058 Assistant Chief Nurse (KB)</p> <p>QA22059 Assistant Chief Nurse (KB)</p>
QA.11.22.9.2	<b>In-patient Survey – Adults – 2021 Benchmark Report</b>	
QA.11.22.9.3	<b>Urgent and Emergency Care Survey</b>	
	<p>MH proposed the surveys be taken as read.</p> <p>KD requested the in-patient survey is brought back to the January meeting, however, noted the results are an improvement on the previous survey.</p> <p>The misprint on the work plan stating that the Accident and Emergency Department survey takes place every two years was noted.</p>	<p>QA22060 Deputy Chief Nurse (JHi)</p>



QA.11.22.10 QA.11.22.10.1	Quality Oversight and Assurance Learning from Deaths including Mortality Review	
	<p>NR was welcomed to the meeting to present the Quarter 2 review and the following key points were highlighted:</p> <ul style="list-style-type: none"> <li>Between 1 July 2022 and 30 September 2022 the Trust has seen 337 adult patient deaths with the Medical Examiner's (ME) Office providing scrutiny to all deaths, and suggesting 30 be subject to a Structured Judgement Review (SJR). By the end of the quarter, 14 reviews had been carried out, six were deaths occurring in Quarter 2 with eight outstanding deaths for Quarter 1.</li> <li>Eleven requests were associated with hospital onset Covid-19 infections – These deaths no longer require review.</li> <li>The reviews of two deaths for Quarter 2 remain outstanding.</li> <li>An additional 11 cases were referred to H M Coroner for inquest with the most frequent reason death following an out of hospital fall.</li> <li>Discussions will be held with H M Coroner in the next few weeks regarding the timely receipt of post-mortem results to enable an SJR to be undertaken providing assurance that any learning from cases is disseminated soon after death.</li> <li>78% of cases were noted to have adequate to excellent care prior to death.</li> <li>Initial care on admission and ongoing care phases demonstrate greater scores of good or excellent levels of care. Where overall care was scored as poor, incidents are subjected to a Stage 2 SJR. In just one of three cases that scored poor overall the Stage 2 corroborated that the patient did receive overall poor care. This case was escalated to the Quality of Care Panel but did not cross the threshold for the declaration of a SI. Learning was collated where poor care was identified and this has been discussed at the Mortality Review Improvement Group with the learning soon to be disseminated in the Quarter 2 report.</li> <li>Highlights of excellent practice in the reviews demonstrated.</li> <li>Of particular note, the Care Quality Commission are clamping down on Trusts where capacity assessments are not being undertaken and work to highlight the importance of assessing capacity throughout a patient's stay is now essential.</li> </ul> <p>National Emergency Laparotomy Audit (NELA) – Discrepancies have been noted between the surgical staff mortality risk scores and the anaesthetic staff risk scores prior to discussions with patients/families regarding surgical risks. A joint session will, therefore, be held with surgical and anaesthetic colleagues to perform training sessions in order improved shared decision-making can be considered.</p> <p>DS noted funding has been approved by Executive Director colleagues to recruit pharmacist and pharmacy technicians to work in the Accident and Emergency Department to improve medicine reconciliation rates due to the number of patients bringing their medication and to reduce the chance of missed medication.</p>	

QA.11.22.10.2	<b>Mortality Review Improvement Programme</b>	
	<p>MM presented the recent improvements noting the increased collaborative and multidisciplinary team efforts:</p> <ul style="list-style-type: none"> <li>• Involvement of the Quality team has been invaluable.</li> <li>• Endoscopy – New policy and guidelines developed to deal with upper GI bleeds.</li> <li>• Escalation and approach around the deteriorating patient and particularly out-of-hours.</li> <li>• Sharing of knowledge and dissemination of information with regards to patients with dementia, palliative care, learning disabilities and mental health illness with these services improved through data collection.</li> <li>• SJR and mortality reviews continue to identify areas for learning.</li> <li>• Evidence apparent for the delivery of excellent care provided on a regular basis and often in challenging circumstances.</li> </ul> <p>MH noted the good work and thanked NR and MM for the information provided.</p>	
QA.11.22.10.3	<b>Medical Examiner (ME) Service</b>	
	<p>An update on the Medical Examiner (ME) service, which continues to be developed, was provided by HA, demonstrating assurance to the Academy as the role, function, aims, resources, current position, progress and challenges were described.</p> <p>The ME Office scrutinises every death in England and Wales liaising with the relatives and doctor, providing feedback into the learning and clinical governance processes. The Learning from Death programme is supported across all healthcare environments and good communication is being developed with all stakeholders.</p> <p>Bradford Teaching Hospitals has between 3000 and 4000 deaths in Bradford to scrutinise per annum with one H M Coroner and one Registry Office to liaise within the City of Bradford. There is a large ethnic population in the city requiring the regular urgent need for body release due to religious reasons.</p> <p>The current position and challenges were highlighted:</p> <ul style="list-style-type: none"> <li>• Good communication and dissemination/sharing of information/learning.</li> <li>• Good working relationships with colleagues at Airedale NHS Foundation Trust.</li> <li>• Recruitment completed in terms of ME and ME Officers.</li> <li>• The ME service is currently scrutinising all deaths in the Trust and is moving to scrutinise all deaths in the community of Bradford, expanding services to General Practitioners.</li> <li>• This national programme is well supported by the Trust.</li> <li>• Continuing to building good relationships with all stakeholders including faith leaders in the community and at the Council.</li> <li>• Continued engagement with GP practices including the development of communication lines.</li> <li>• Scrutinised 100% of 345 deaths in the last Quarter with ten</li> </ul>	

	<p>referred from the Learning from Deaths team and 23% referred to H M Coroner.</p> <ul style="list-style-type: none"> <li>• The whole ME process should become statutory and legal in April 2023, however, has not yet been signed off officially to commence in April 2023.</li> <li>• Only a doctor who has seen or treated the patient in the last 28 days can sign the death certificate.</li> <li>• Out-of-hours funded service to be instigated.</li> <li>• Feedback provided to the Regional Medical Examiner and Board as required.</li> </ul> <p>MH noted the helpful information provided questioning where the burden of complying lies with the law in April 2023. This question has been asked to the national programme, however, the gatekeeper at present would be the Registrar of Births and Deaths.</p> <p>LT noted the SJR findings are not currently shared with individual families. Consideration may be given to share the learning with public and patients more widely, however, this would require further consideration.</p> <p>HA noted the proportion of deaths referred to H M Coroner or the Learning from Death team are broadly the same as other areas in the region.</p> <p>It is noted H M Coroner receives 30 to 40% of referrals nationally. BTH's referrals are currently lower, however, but the Trust is only looking at hospital deaths at present. It is considered community referral to H M Coroner will be greater. Referral numbers have not changed significantly over the last few quarters.</p> <p>MM, as Chair of the Regional Mortality Improvement Group, noted approximately 10 to 15% of total deaths are being referred for SJRs/Learning from Deaths, in other Trusts.</p> <p>The Academy also noted with the commencement of the review of community deaths an SJR would not be undertaken as these do not occur in the Trust.</p>	
<b>QA.11.22.11</b>	<b>Nursing and Midwifery Leadership Council Update (Magnet4Europe)</b>	
	This item was taken as read by the Academy.	
<b>QA.11.22.12</b>	<b>Update on Health Inequalities (HI)</b>	
	<p>The presentation was taken as read by the Academy with JHo noting this submission ensures the Academy is fully aware of the work underway in respect of health inequalities.</p> <p>JC agreed to meet with JHo to discuss the elements of the HI workstream linked to the Quality Strategy as HI will be a key component of the CSU service considerations and clearly linked to the governance agenda. JHo also requested a discussion with JC around patient safety facilitators. JC and JHo will meet separately to discuss these issues.</p>	QA22061 Director of Strategy and Integration

	<p>JC noted connection to the Quality Strategy through aspirations and deliverables, challenges and risks with operations and performance and the associated targets.</p> <p>Quality improvement methodology and national strategies will drive this work, however, the Trust's priorities over the next three to five years will ensure delivery in this challenging healthcare environment.</p> <p>JHo noted HI is a standing item on the agenda for the Equality and Diversity Council and this will be a component of the Equality, Diversity and Inclusion Strategy for the Trust, in order this stands up to scrutiny and is fully cohesive.</p>	
<b>QA.11.22.13</b>	<b>Introduction of New Clinical Procedures or Techniques Policy</b>	
	<p>The paper was taken as read and the Academy approved the updated Policy.</p>	
<b>QA.11.22.14</b>	<b>High Level Risks</b>	
	<p>The Academy was assured that all relevant key risks have been identified and reported.</p> <p>MH noted this excellent detailed paper and the assurance provided. The paper was taken as read and KD provided the key highlights.</p> <p>Risk 3815 – Unable to validate Maternity data extracted from Cerner EPR, following the implementation of the new EPR system in Maternity. This risk is being very actively managed by KD and PR. The data shared on the Maternity dashboard both internally and externally is incorrect and may result in an untrue regional and national picture and may prevent the Trust obtaining a 'good' CQC rating.</p> <p>Prior to the implementation of the new system one to one care in labour rates were affected. KD expected this score to reduce over the next six months following the meetings planned between Maternity and Informatics.</p> <p>This score was noted to be sufficient as further mitigation and security is not required following a robust risk assessment undertaken from both a clinical and business intelligence point of view with oversight from Maternity leaders and Executives. This is more a reputational risk as full maternity data sets cannot be reported. Other processes are in place to capture some of this considered skewed data.</p> <p>New Risk 3810 – This new risk regarding the Haematology Consultant team and Haemophilia service delivery was highlighted by RS and the situation considered to be relatively short-term and to due to resolve around February 2023.</p> <p>Neighbouring Trusts, particularly Leeds, have been very helpful in supporting the Trust and continue to accept urgent haemophilia referrals, however, waiting times are impacted. There are no</p>	

	<p>available locums in this very difficult to recruit to specialty. The Trust is currently looking to integrate/combine the service with Airedale and implement a single service with pathways being drawn up. This project is difficult to progress without the current establishment.</p> <p>KD highlighted the difference between the shorter and longer term risks noting the longer term risks are not necessarily those considered as not being managed appropriately. These are wider issues that may always remain an issue for example nurse staffing and the financial challenge of budgets. The Trust is fully sighted, mitigated and reviews on a regular basis.</p> <p>Risk 3808 - KD noted the Trust only received notice of the strike action dates on 29 November 2022 and that the risk is currently being updated. Assurance was provided that this risk is a regular item currently discussed at all Executive meetings and briefings and a further update will be provided at the Board Development session on 8 December 2022.</p> <p>JH highlighted the lengthy discussions on this topic at the Finance and Performance Academy meeting on 30 November 2022 and RS at the People Academy on 30 November 2022.</p> <p>New Risk 3660 concerned the rapid increase in the number of attendances at the paediatric Emergency Department and Children's Clinical Decision Area. RS noted paediatric services are under pressure nationally and the peak winter pressures are now expected around the end of December 2022. The whole paediatric team are meeting regularly with the Executives.</p> <p>JH discussed the risk relating to the Stroke Service, discussed at the Executive team meeting, due to the current issues impacting the service, including increased demand and staff vacancies particularly speech and language therapists. JCI noted the national shortage of these specialists who require subsequent training to manage dysphagia, once qualified, due to the risks attached to this specialism. This is very complicated from the stroke perspective by needing a live caseload of patients. Speech and language therapists are usually small in number and there is a high demand nationally for this specialism. The risk is anticipated long-term to the Trust service. Any national agenda to improve training would be initiated with a Deanery discussion from a University. The situation is, however, on the national agenda as this is a countrywide position.</p> <p>RS noted recent discussions with the Trust Executive and the University of Bradford which addressed shortages amongst all therapies and in particular Speech and Language therapists. At a recent capital meeting approval was received for the fast-tracking of speech and language recruitment due to this being a key factor in the Sentinel Stroke National Audit Programme (SSNAP) scores for stroke and quality care for patients. Work continues with the University to encourage recruitment to this specialty.</p>	
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	MH referenced Risk 3660's description referencing August 2021 and requested an update to demonstrate the current position.	QA22062 Chief Nurse
<b>QA.11.22.15</b>	<b>Any Other Business</b>	
<b>QA.11.22.15.1</b>	<p>MH raised the issue of the timing of the Academy meetings and proposed the meetings revert back to two and a half hours in length.</p> <p>LP suggested two hours for the Assurance meeting with the Learning and Assurance meeting moving to two and a half hours.</p>	QA22063 Associate Director of Corporate Governance/ Board Secretary
<b>QA.11.22.16</b>	<b>Matters to share with Other Academies</b>	
	There were no matters to share with the other Academies.	
<b>QA.11.22.17</b>	<b>Matters to escalate to the Board of Directors</b>	
	There were no matters to escalate to the Board of Directors.	
<b>QA.11.22.18</b>	<b>Date and time of next meeting</b>	
	Wednesday, 14 December 2022, 2 pm to 4 pm - Assurance meeting.	
	<b>Annexes for the Quality and Patient Safety Academy Annex 1 – Documents for Information</b>	
<b>QA.11.22.19</b>	<b>Patient Safety Group</b>	
	Noted for information.	
<b>QA.11.22.20</b>	<b>Clinical Outcomes Group</b>	
	Noted for information.	
<b>QA.11.22.21</b>	<b>Patient Experience Group</b>	
	Noted for information.	
<b>QA.11.22.22</b>	<b>Clinical Audit Annual Report 2021/22</b>	
	Noted for information.	
<b>QA.11.22.23</b>	<b>Care Quality Commission Report on the state of healthcare and adult social care in England 2021/22</b>	
	Noted for information.	
<b>QA.11.22.24</b>	<b>Research Update</b>	
	Noted for information.	
<b>QA.11.22.25</b>	<b>Quality and Patient Safety Academy Work Plan</b>	
	Noted for information.	



## ACTIONS FROM QUALITY AND PATIENT SAFETY ACADEMY – 30 NOVEMBER 2022

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
QA22035	29.06.22	QA.6.22.14	<b>Serious Incident Report</b> Clear expectations are apparent in the new quality governance framework and this will be embedded/articulated in the Quality Strategy which it is envisaged will be presented in draft format to the Academy in October.	Associate Director of Quality	December 2022	12.10.22: JC – First draft circulated to key individuals for comment and contribution. To move to December 2022 due to delay in responses.
QA22055	26.10.22	QA.10.22.9	<b>High Level Risks</b> No specific risks are currently aligned to obstetric and maternity staffing, however, risk assessments have been undertaken for listing on the Corporate Risk Register. SH agreed to add this documentation as an appendix to the November report being presented at the December QPS Academy once approved via the Maternity Governance group.	Director of Midwifery	December 2022	23.11.22: SH - Risk assessment included in the November update paper. Completed. <b>CLOSED.</b>
QA22056	30.11.22	QA.11.22.6	<b>Quality Account – Progress Report</b> PSo agreed to provide data to benchmark the Trust against other Cerner Trusts regarding sepsis screening and Time to Treat.	Associate Medical Director (PSo)	December 2022	09.12.22: Action update requested.
QA22057	30.11.22	QA.11.22.8.1	<b>Learning from Maternity Health and Safety Investigation Branch (HSIB) Reports</b> It was agreed that full SI reports will now be attached and included in the SI report.	Associate Director of Quality	December 2022	09.12.22: Action update requested. 12.12.22: Action completed by JC. <b>CLOSED.</b>
QA22058	30.11.22	QA.11.22.9.1	<b>Patient Experience – Six Monthly Report</b> The improvement work in the last quarter was particularly noted around the new Carer policy, passport and charter which now includes young carers. It was agreed that the reference	Assistant Chief Nurse (KB)	December 2022	07.12.22 – KB has requested with Communication with Patients Advisory Group and Medical Illustration for the change to the form to be made. Completed. <b>CLOSED.</b>

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
			on the Unpaid carer care plan and agreement, 'feeding' would be amended to 'managing nutrition' in order to be more dignified and inclusive.			
QA22061	30.11.22	QA.11.22.12	<b>Update on Health Inequalities (HI)</b> JC agreed to meet with JHo to discuss the elements of the HI workstream linked to the Quality Strategy as HI will be a key component of the CSU service considerations and clearly linked to the governance agenda. JHo also requested a discussion with JC around patient safety facilitators. JC and JHo will meet separately to discuss these issues.	Director of Strategy and Integration	December 2022	07.12.22: Confirmed action could be closed by John Holden, Director of Strategy and Integration, meeting being arranged. Completed. <b>CLOSED.</b>
QA22062	30.11.22	QA.11.22.14	<b>High Level Risks</b> MH referenced Risk 3660's description referencing August 2021 and requested an update to demonstrate the current position.	Chief Nurse	December 2022	13.12.22: Risk 3660 confirmed as updated by KD. Completed. <b>CLOSED.</b>
QA22063	30.11.22	QA.11.22.15.1	<b>Any Other Business</b> MH raised the issue of the timing of the Academy meetings and proposed the meetings revert back to two and a half hours in length.  LP suggested two hours for the Assurance meeting with the Learning and Assurance meeting moving to two and a half hours.	Associate Director of Corporate Governance/ Board Secretary	December 2022	09.12.22: Completed. <b>CLOSED.</b>
QA22019	27.04.22	QA.4.22.10	<b>Maternity and Neonatal Services Update</b> JH noted the excellent research facilities in the Trust. MH asked if the Bradford Institute for Health Research related to perinatal mental	Director of Midwifery	January 2023	19.05.22: SH to meet the BiBS team to discuss. 19.07.22: SH still to meet with the BiBS team to discuss. Update to be

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
			health was embedded into practice. SH said that she would follow this up.			provided in September. 30.08.22: Deferred at SH request, update to be provided in October 2022. 26.10.22: SH – No output following initial contact. Teams considering the conversations and outputs.
QA22020	27.04.22	QA.4.22.13	<b>Clinical Outcomes Group</b> Two Policies due for renewal will be submitted to the June Academy.	Associate Medical Director (PM)	January 2023	16.06.22: Work in progress. Suggested timescale October 2022, owing to new Clinical Governance Framework due to be implemented from September 2022. 29.06.22: Item deferred until the October meeting. 14.10.22: LT – Introduction of New Clinical Procedures or Techniques Policy and Clinical Audit Policy including National Confidential Enquiries to be submitted to the November 2022 meeting. 17.11.22: Introduction of New Clinical Procedures or Techniques Policy on November agenda. Clinical Audit Policy including National Confidential Enquiries deferred until the January 2023 meeting.
QA22037 QA22042	27.07.22	QA.7.22.5	<b>Quality Oversight and Assurance</b> <b>A – Quality Oversight and Assurance Profile</b> <b>B – Serious Incident (SI) Report</b> JC raised the issue of the necessity of data available to support and noted that following	Associate Director of Quality	January 2023	31.08.22: JC has discussed with Carl S the balance score card to ensure the CSUs have the appropriate metrics to monitor quality at CSU level. 28.09.22: Work underway with the

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
			<p>initial discussions with PR, PSo, Sajid Azeb (Chief Operating Officer) and Carl Stephenson (Associate Director of Performance) this matter will be passed to the Finance and Performance Academy in order further quality metrics may be added to the dashboard.</p> <p><b>Matters to Share with Other Academies</b> QA.7.22.5 – Collation of information systems concerning learning from harm – Following initial discussions with PR, PSo, Sajid Azeb (Chief Operating Officer) and Carl Stephenson (Associate Director of Performance) this matter will be passed to the Finance and Performance Academy in order further quality metrics may be added to the dashboard.</p>			<p>new Clinical Support Units (CSU) which were recently introduced. New Quality and Patient Facilitators have being aligned to the new CSUs. An update on the Ward to Board metrics will be available in a few months once these new roles are embedded and the new Quality and Safety meetings introduced.</p>
QA22059	30.11.22	QA.11.22.9.1	<p><b>Patient Experience – Six Monthly Report</b> KB noted the difficulties sometimes experienced in retrieving information from the Trust's Datix system, due to limitations as how best to represent data. There have been previous discussions about how data could be improved as a large amount of data was reflected as "other". KB took as an action to revisit this again, to discuss and consider any options that would provide more meaningful data to this cluster. This system may be upgraded in time. Trust systems should, however, function fully.</p>	Assistant Chief Nurse (KB)	January 2023	07.12.22 - KB has contacted the Complaints Lead and Datix team and is awaiting feedback.
QA22060	30.11.22	QA.11.22.9.3	<p><b>Urgent and Emergency Care Survey</b> KD requested the in-patient survey is brought back to the January meeting, however, noted</p>	Deputy Chief Nurse (JHi)	January 2023	09.12.22: Item added to the January 2023 agenda. Completed. <b>CLOSED.</b>

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
			the results are an improvement on the previous survey.			
QA22032	29.06.22	QA.6.22.6	<b>Urology Serious Incident</b> A report is expected to be presented to the Academy on the findings from the working group including learning and improvements.	Deputy Chief Medical Officer (LAE)	February 2023	
QA22050	26.10.22	QA.10.22.5	<b>Quality Oversight and Assurance Profile</b> The possibility of communication barriers having led to omissions, confusion or misunderstandings may be relevant and this issue will be escalated to the Board of Directors.	Associate Director of Corporate Governance/ Board Secretary	February 2023	18.11.22: LP: Dependent on the outcome from the paper to be presented by Adele Hartley-Spencer in February with findings in relation to communications/interpreters. QPSA then to determine if this should be escalated to the Board of Directors.
QA22051 / QA22054	26.10.22	QA.10.22.5	<b>Quality Oversight and Assurance Profile</b> AHS will work with Patient Experience and the Interpreting Services to consider direct risks (local/strategic) around language/ communication/interpreters and will provide a review in four months.	Associate Director of Nursing (AHS)	February 2023	09.12.22: Linked to QA22054 at KD's request.
QA22054 / QA22051	26.10.22	QA.10.22.9	<b>High Level Risks</b> MH raised the issue of language communications and any risks documented below the 'high risk' level for review. RS agreed to search the risk register in order to identify any risks to highlight.	Chief Medical Officer	February 2023	18.11.22: RS: There are no currently open risks on the risk register relating to communication difficulties. Consideration is being given as to how to articulate this risk for escalation. JC meeting with KD and JHi to further discuss (29.11.22). 30.11.22: Looked into this and nothing specific on high level risk on register. KD identified AHS in the October meeting to set up a Task



## Bradford Teaching Hospitals

NHS Foundation Trust

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
						and Finish Group to look at whether this is an issue, whether it is wider, as picked up as a theme in some of the maternity incidents. AHS to undertake thematic review of incidents, risks and looking at patient experience from contacting interpreters from the Trust services. Piece of work underway will take at least three months to conclude. However, if there is evidence to suggest it is a risk that should be on the higher level risk register, it will be updated prior to this time, should this come to light. 09.12.22: Linked to QA22051 at KD's request.
QA22064						

### Assurance Meeting Actions

### Learning and Improvement Actions