Bradford Teaching Hospitals NHS Foundation Trust

Board of Directors			
Date	**19 January 2023**	**Agenda item:**	**Bo.1.23.11**

Report from the Chair of the Quality and Patient Safety Academy (QPSA) held 30 November 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 QPSA held **30 November 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	QPSA held 30 November 2022	
Previously approved at:	**Committee/Group**	**Date**
	N/A	

Key Matters Discussed

A summary of the key items discussed at the meeting held in November is presented below. The confirmed minutes from the meeting will be available at Board in January 2023. The next meeting of the QPSA is scheduled for 14 December 2022.

This meeting is the second in the revised format of the academy meetings where alternate meetings will focus on Assurance in one month and Learning and Improvement in the other. This meeting focussed on Learning and Improvement.

Overview of the QPSA Learning and Improvement meeting held 30 November 2022

Key items discussed.

1. Quality Strategy and Patient Safety Incident Response Framework (PSIRF)

The Academy received an overview on the development of the Trust's Quality Strategy and noted that a first draft had been completed, which draft draws on the National Quality Board recommendations to develop a shared single view of Quality. The Academy also pleased to note the developments with regard to PSIRF, namely the analysis of data about to be undertaken with Bradford Institute of Health Research as part of the diagnostics and recovery phase.
In particular, the Academy was assured that changes with regard to the CQC quality statements were also a guiding factor in the development of the Quality Strategy and, that a strong focus would be placed on equality and inclusion bearing in mind the recent conversations at Board (and the Academy) with regard to language and communications.

2. Quality Account: Improvement Priorities Progress Update

A comprehensive update was received on two of the four priorities; 'Improving the Management of Deteriorating Patients' and, 'Advancing equality, diversity and inclusion'. A detailed discussion took place with regard to the Cerner EPR algorithm and the low percentage presented with regard to sepsis screening (60%). The figure has also lowered by approximately 10% since the addition of data from the Maternity EPR. The complex issues were shared with the Academy which related primarily to when and where it was appropriate to record the sepsis status of patients

(rather than just using the option of a simple yes/no statement at the start of their treatment which clinicians could, and do, bypass if the clinician decides that this is warranted). Once the status of the patient is determined the '60% rate' is not borne out by the figures presented for the management of sepsis and the 'time to antibiotic treatment'. The Academy has requested that further updates should include any available data to support benchmarking against other Trusts.

3. Serious Incidents (SI): Focus on Learning

The learning from two very different SIs was discussed in detail by the Academy. With regard to one of the SIs, the Academy noted, and applauded, the actions taken in advance of the completion of the SI investigation which reflected the proactive approach by the team to the immediate learning from the event. The second SI discussed focussed on the learning from a complex case where an initial error with regard to the wishes of the patient as reflected on the ReSPECT form (Recommended Summary Plan for Emergency Care and Treatment) was miscommunicated during a nursing handover. The Academy in particular noted the actions underway to seek to address the broader issue with regard to incorporating the ReSPECT form into EPR to enable a person's wishes to be considered by all parties involved in their care.

4. Learning from Maternity Investigation Branch (HSIB) Reports

The Academy received an overview of the investigations undertaken with HSIB since its inception in 2017. This included a discussion with regard to the relationship that had developed with Maternity services and the HSIB team. The Academy was pleased to note the quality and oversight of investigations exercised by the ICB which is in receipt of all HSIB reports. The ICB was focussed on supportive conversations that led to a more collaborative approach aimed at improving the patient experience.

The Academy also discussed the reporting with regard to SIs and was reminded that Maternity services undertake a review of cases within 72 hours of an SI being declared and implements any learning identified as a result of that 72 hour review. The team does not wait for the outcomes from the HSIB report. The Academy was also reminded of the reporting in place with regard to SIs (to the Academy and to Board) which included the timelines for SIs, the timeframe in which they were opened and concluded, along with reference to the key learning and oversight with regard to the completion of the recommendations. It was agreed however that in future the full reports on any SIs would be included as part of the document pack provided to the Academy.

5. Patient Experience (bi annual report, adults in-patient survey)

A comprehensive report was received on Q1 and Q2 activity and learning during the last 6 months. Of particular interest to the Academy were the themes emerging regarding 'rude staff' and the measures put in place to address this. Mitigations included customer service training for front facing reception staff and raising awareness around civility and kindness. Whilst these behaviours were not acceptable, the Academy was also keen to hear that as a 'caring employer' engagement with psychological services was also underway, to seek to understand behaviours in order to better address them and effect change. The other key issue for the Academy was the way in which the data was presented with regard to the overall themes for complaints where 37% were described as 'other'. The Academy has requested further clarity with regard to this categorisation.

6. Learning from Deaths, Mortality Review and, Medical Examiner Service

Comprehensive reports were received on each of these areas. The Academy sought confirmation on the Trust's performance in this area and it was confirmed that the results were comparable with

those from other hospitals across the region. With regard to the Medical Examiner Service the process becomes statutory in April 2023. GP recruitment is slower than hoped, which is a position reflected nationally. Much has been achieved including the establishment of a reliable ME service for adults in the acute hospital setting and the Trust is in a unique position to learn from the care given in all settings.

7. Update on Health Inequalities

The Academy welcomed the update and acknowledged the need to ensure that Health Inequalities was threaded through the new Quality Strategy and the new EDI strategy. It was noted that this was a standing item at the EDI Council meetings (chaired by the CEO). The Academy also referred to the Quality Strategy and requested that particular care was taken with regard to the aspirations set to ensure that these were realistic and could be delivered. The Academy looked forward to receiving future reports on work in this area.

8. Introduction of New Clinical Procedures or Techniques Policy

The Academy approved the policy.

9. High Level Risks

The Academy noted the comprehensive report. The Academy was sighted in particular on the following risks and the mitigations in place.

- Risk 3815: There are concerns regarding the data extracted from the Maternity EPR as it does not correlate with information input.
- Risk 3810: Haematology Consultant Team and Haemophilia service delivery.
- Risk 3808: Royal College of Nursing Strike Risk. (The Academy noted that this had also been discussed in detail at both the People and Finance & Performance Academies although there remain many unknowns.
- Risk 3660 concerned the rapid increase in the number of attendances at the paediatric Emergency Department and Children's Clinical Decision Area.

The Academy confirmed that it was assured that all relevant key risks have been identified, reported to the Academy, and were being managed appropriately.

10. Any Other Business

The Academy has agreed to extend the meeting time for its Learning and Improvement meetings from 2 hours to 2 ½ hours.

Items of Positive Assurance, Learning and/or Improvement

As Chair of the Academy, I would like to highlight from this month's meeting the following two key items:

3. Serious Incidents (SI): Focus on Learning. In particular the candour with which the learning was shared and, the ability of Trust staff to admit their mistakes in the handling of a patient's care and seek to ensure changes in behaviours that lead to the 'whole patient' is taken account of.
7. Learning from Deaths, Mortality Review and, Medical Examiner Service. The comprehensive reporting and work undertaken across all these areas - in particular the Medical Examiner Service reporting and the work undertaken to ensure the Trust itself is in a good place by the time the Medical Examiner service becomes a statutory requirement in April 2023.

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Matters escalated to the Academies or Board of Directors for consideration

There is nothing to escalate.

New/emerging risks

The following three new risks have been aligned to this academy:

- Risk 3815: There are concerns regarding the data extracted from the Maternity EPR as it does not correlate with information input.
- Risk 3660: The rapid increase in the number of attendances at the paediatric Emergency Department and Children's Clinical Decision Area.
- Risk 3808: Industrial action including strike action given that the RCN have voted in favour of strike action and Unison, CSP, and the RCM are currently balloting.

There were no emerging risks arising from the meeting.

Strategic Commitments considered at this meeting

The reports presented at this meeting were relevant to the following strategic commitments and key areas of work:

Individual strategic commitments	Key areas of work
Patients **Our ambition -** We are committed to making a difference to everyone who needs our care. We recognise that that we will best do this by developing high quality, innovative services and by continuing to develop and embed a culture of kindness to ensure a positive patient experience.	
Pat1 - The delivery of outstanding nursing and midwifery care	**Pat1b** - Senior staff to be empowered to resolve key issues and develop services
Pat2 - Providing outstanding patient experience	**Pat2a** - Further development and delivery of the *Embedding Kindness* programme
	Pat2b - Engagement with patients so that they have a voice and can see that their voice is being heard.
	Pat2c - Continue to collate information and feedback from FFT, national surveys and specific patient experience projects
Pat 3 - Delivery of high quality services	**Pat3a -** Implement new Quality Strategy with focus on the WHO 6 areas of Safety, Timeliness, Effectiveness, Efficiency, Equity and Patient Centric care
	Pat3b - Support for clinicians to implement specific programmes of improvement

Recommendation

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

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