

Board of Directors			
Date	10 November 2022	Agenda item:	Bo.11.22.18

Report from the Chair of the Quality and Patient Safety Academy (QPSA) held 26 October 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 26 October 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 26 October 2022		
Previously approved at:	Committee/Group	Date	
	N/A		

Key Matters Discussed

A summary of the key items discussed at the meeting held in October 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 30 November 2022.

This meeting was the first of the new style meetings where alternate months will cover QPSA Assurance and, QPSA learning and improvement. This meeting covered assurance.

Overview of the QPSA Assurance meeting held 26 October 2022: Key items discussed.

1. Quality Oversight and Assurance Profile

The Academy held an extensive discussion focussed on interpreting and language barriers. It was noted that whilst this is detailed and scrutinised with regard to the delivery of Maternity services, the Academy is not sufficiently assured that this area has sufficient oversight at a more strategic level - particularly as the consequences of decisions made can lead to sub-optimal care. The Academy recognises that this is a complex area and concluded that if decisions and circumstances surrounding the use (or not) of the varied range of interpreting services are not fully documented and assessed then this can provide a lack of transparency and understanding. The Academy will review this further at the next assurance meeting and will determine at that point if there is need to escalate this to the Board with regard to broader strategic issues.

2. Serious Incident Report

A detailed report was received and discussed which covered the period 16 September to 15 October 2022.

- There are 22 ongoing Serious Incidents (SIs)
- 4 were declared between the reporting period and 1 was closed.

As well as a focus on individual SI's; the Academy discussed in detail the tracking and completion of the actions identified as the current reporting did not provide sufficient assurance that learning and improvements have/are being embedded. There was a candid and open discussion held.

The Academy concluded that with regard to the question of 'are we assured that we have the right

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processes in place'; the conclusion at the present time is that we are 'nearly there'. The Academy looked forward to receiving the updated Complaints, Litigation, Incidents and Patient Experience (CLIP) Report and the additional information requested to support assurance within this area.

The Academy also discussed the requirement for clarity with regard to reporting on still births and other investigations to ensure that the Academy is clear on the associated time-frames. The Academy noted that at times actions and outcomes from external reports might not be received anywhere from 6 to 18 months after the event was logged. Future reporting would ensure that the timeframes were clear.

3. Quality and Patient Safety Academy Dashboard

There was a good discussion with regard to the dashboard and it was good to note the following positions:

- The Hospital Standardised Mortality Ratio (HSMR) and the Summary Hospital-level Mortality Indicator (SHMI) were within expected ranges
- BTHFT readmission rates continue to fall. BTHFT are the best performers within the West Yorkshire Association of Acute Trusts (WYAAT)
- The continuing improvement trends with regard to Category 3 pressure ulcers
- The improving picture with regard to the prevalence of C.Difficile and MRSA and,
- The continued reduction in the number of 'Falls with Harm' recorded.

The Academy also discussed in detail the following:

- The 'Percentage of deaths scrutinised by the Medical Examiner'. Whilst this sits at 100% for BTHFT - deaths scrutinised within the community sits at approximately 20% of all GP practices. The Academy heard that there is a statutory requirement to ensure that we scrutinise 100% of deaths by April 2023 - which is not achievable. BTHFT is ahead of the vast majority of organisations (both nationally and regionally) however it is recognised that the target remains aspirational.
- The Sepsis Screening level remains at approximately 60%. This relates to how the Trust records screening and not about the care provided. The Academy noted the continued mitigations in place, as reported at the previous meeting.

The Academy agreed to the removal of the metrics for Breastfeeding, at the present time, due to the reported issues on the accuracy of the data. A statement will be recorded on the dashboard to this effect and once issues have been resolved the metric would be reactivated.

4. High Level Risks

Following the discussion of the risks the Academy has determined that there are no issues relating to these risks to highlight to the Board in November. The Academy in particular noted:

- One risk has changed score. Risk 3686: Antenatal Clinic Waiting Area. This has reduced from 15 to 9. A number of the pods have been removed creating more space and seating leading to a more comfortable area for women and, making it much easier to navigate Women moving through this area to the delivery suite.
- Two of the risks significantly past their original mitigation dates have now been updated in line with a decision to undertake in depth reviews on such risks. These are 3411: Oncology vacancies and 3991: Ventilation in the pathology laboratories. The Academy discussed in detail risk 3411 and the work which has been undertaken by West Yorkshire Association of Acute Trusts (WYAAT) led by the Cancer Alliance to create joint appointments for Leeds, Bradford and Airedale. This is a different position since the risk was first articulated and the relevant team is working to reframe and articulate this risk.
- Risk 3473: Child development waiting lists and the associated staffing issues. The Academy

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discussed the difficulties of attracting staff to Bradford and the solutions and mitigations being explored including using and developing the skills of staff in more creative ways.

5. Board Assurance Framework: Strategic Risks relevant to the Academy

The Academy complemented the new style reporting. Two key items discussed in detail were;

- The threat of industrial action: This would be added to the next iteration of the report. The Academy also noted the discussions currently taking place at the Executive Team Meeting and that a risk would be formulated, scored and then added to the register.
- Increased visibility with regard to Research: The Academy noted the increase in focus on the area of Research now received at Board however it was keen to see a much greater focus on this area and in particular to articulate better the tangible impact Research has on the Trust and our populations. The Academy concluded that it would be useful to review best practice from other organisations to support any future reporting at BTHFT.

6. Infection Prevention and Control (IPC) Board Assurance Framework (BAF)

A comprehensive and streamlined report was presented. The September position reflected rates with regard to C. Difficile and MRSA that mirror the national and regional position. Gaps in compliance were highlighted along with the challenges and actions taken to mitigate these. Assurance was provided with regard to the focus on the Covid19 improvement programme and, with regard to the Winter plans.

7. Maternity and Neonatal Services Update

The Academy received a comprehensive update on the September position. Key to note was that following the spike in still births in August, there was a downturn in September and a rise in October. A review has been undertaken and the conclusions tended towards socio-economic factors. The Academy was particularly pleased to note the work undertaken in response to concerns about the economic crises and the impact on vulnerable women. Direct support has been solicited from Bradford Metropolitan District Council foodbanks who are delivering parcels directly to Maternity Services for their distribution. Maternity Services is continuing to work on how it identifies those women most in need and are enquiring about barriers the women face and signposting them to additional support. Other initiatives such as transport are also being reviewed as many of the women who have not attended appointments (DNAs) cite the cost of transport as a factor. This could have severe implications for the health of their babies.

The Academy was disappointed regarding the challenges brought by the staffing position and the challenges faced within Maternity. The Academy did welcome the appointment of a formerly retired obstetrician to support the analysis of all still births in year to support the identification and focus of improvement activities. The Academy noted that obstetric colleagues are particularly receptive to this support.

8. Bi-Annual Digital Report

A comprehensive and detailed report was received. In particular the Academy focussed on:

- Developments with regard to the Virtual Royal Infirmary
- The success of the Omnicell automated medication dispensing system
- A status report on the digital capital programme. Here a number of capital investment programmes had slipped however some were expected to recover in year. The largest one affected was an overhaul of the Wi-Fi system and infrastructure which is a multi-year project.

The Academy also noted the vacancies being carried at the present time leading to the team being under-resourced.

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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:

1. Quality Oversight and Assurance Profile. The Academy is keen to receive a strategic overview of interpreting and language services across the Trust as a whole to gain greater understanding of how these are used and any areas of learning and improvement that can be applied.
7. Maternity and Neonatal Services Update. The Academy is fully supportive of the appointment aimed at undertaking an analysis of the previous year's data which will support the development of informed interventions to support reductions in still-births.

Matters escalated to the Academies or Board of Directors for consideration

The QPSA would like to make the Board aware of the discussion regarding interpreting and language barriers under section 1 and, the request for a report to determine if a risk needs to be added to the risk register.

New/emerging risks

There were no new or emerging risks arising from the meeting.

The Board is requested to note the discussions and outcomes from the Quality and Patient Safety Academy held on 26 October 2022.