Bradford Teaching Hospitals NHS Foundation Trust

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

Report from the Chair of the Quality and Patient Safety Academy held 28 September 2022

Presented by	Mohammed Hussein, 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 **28 September 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 28 September 2022	
Previously approved at:	**Committee/Group**	**Date**
	N/A	

Key Matters Discussed

A summary of the key items discussed at the meeting held in September 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 26 October 2022.

Overview of meeting held 28 September: Key items discussed

1. Falls With Harm

Due to an increase in falls noted at the end of the last quarter the Academy had requested a special item to be added to this agenda to enable a more detailed and in-depth look at the challenges and issues. The informative report focussed on the positive changes made and continued engagement around falls with harm. To further support an understanding of the changes a future session of the Academy will be hearing directly from teams at ward level on how they use their own data, alongside shared learning, to support quality improvements.

2. Estates and Facilities Update with a focus on the Catering Service and an update on the Nutritional Group

The academy had also sought further assurance regarding the catering service and the nutrition steering group plans in response to an element of the patient survey results received at a previous meeting. A thoroughly comprehensive report was received providing good levels of assurance. The detailed discussion focussed particularly on a number of core areas including diversity, the effects on the service during the pandemic and, the move towards restarting with the reinstatement of the PLACE visits.

3. Quality Improvement (QI) Programme Quarterly Update

This was another thoroughly comprehensive report. The Quality Team are to be commended for the step changes they have made over the last couple of years in terms of the focus on Quality and Quality Improvements and the Board's attention to those particular achievements highlighted in the minutes with processes becoming more embedded. It is also important to note the

importance of non-clinical staff also helping to facilitate change in clinical care.

4. Progress Update from Quality and Patient Safety Academy Development Session

An ambitious programme of change has been agreed by the Academy. Key to note is the delivery of 12 meetings per year with six focussed on assurance and six on learning and improvement. This would afford a better use of time for all participants. Membership of the Assurance meetings will be smaller including the Non-Executive Directors, lead Executives and key senior managers to support more focused discussion. The learning and improvement meetings will have a broader membership so that insight can be sought from, and shared with, a broader range of staff. It is also pleasing to note of the plan to deliver an annual celebration open event showcasing Quality Improvement within CSUs.

5. Outstanding Theatre Service (OTS) Programme – Quarterly Update

Assurance was provided with regard to adherence to 'the five steps to safer surgery'. The change of behaviours and culture was found to be both reassuring and encouraging. The Academy has noted that the processes now need to be embedded and sustained and looks forward to receiving further updates on this long-term project.

6. Quality Oversight and Assurance

The comprehensive report covered serious incidents, PALS and complaints, Alerts, organisational learning, claims and inquest data along with learning from internal and external risks. As well as the improvement work underway to address the number of open Datix incidents. Key highlights from the comprehensive report and discussion held are flagged below.

- Serious Incident (SI) Report: In the last month six SIs have been declared by the Trust. One of these was a Never Event. The Academy discussed these in detail and noted that the reports and action plans submitted to the Healthcare Partnership have been accepted with positive feedback received on the improvement measures highlighted. There are 6 SIs which have been concluded during this period and 19 SIs are ongoing. Six of the 19 are being led by the Healthcare Safety Investigation Branch (HSIB). The Academy has noted the current position and from the reporting received is assured that Trust has processes in place to identify, investigate, improve and learn from SIs.
- Patient Experience: The number of compliments increased during July and August. With regard to Complaints and PALS issues; Care and treatment remain as the top themes. Fewer complaints and PALs issues were responded to during July but responses did however increase in August. The Academy did raise concerns regarding those complaints that remained unclosed beyond six months however it did hear that there is a focus on reducing these complaints and further noted that a key factor was their complexity.
- Quality and Patient Safety Facilitators: It was also good to note that each of the new CSUs had a Quality and Patient Safety Facilitator now assigned to support improvement work with the embedding of the Quality Governance Framework.
- Requests for key reporting: The Academy is keen to receive information for:
  - The lessons learned with regard to claims that are upheld.
  - Protected characteristics to be provided where possible for incidents occurring in the Trust.
  - Information that could be provided with regard to interpreting and, the identification of those with additional needs

7. High Level Risks

Following the discussion of the risks the Academy has determined that there are no issues

relating to the risks to highlight to the Board in November. Of particular note is that there have been no changes to the risks except for Risk 3309 which has reduced in score. Risk 3309 relates to "Risk of harm to patients and the organisation from delays in processing histopathology samples" and a further in-depth review of this risk is scheduled.

Following on from the discussion at Board in September, the Academy is sighted on a number of risks have been on the register for a considerable period of time and is assured that these continue to be reviewed regularly.

8. Quality and Patient Safety Academy Dashboard

The following key highlights were noted from the detailed discussion with regard to dashboard.

- Fall in readmissions: The data was very encouraging as the reduction has been sustained. BTHFT has one of the lowest 'length of stay' rates in the region.
- The downward trend with regard to Category 3 pressure ulcers continues which is good news. The Academy noted that the higher level was due to the use of non-invasive ventilation during the Covid pandemic.
- Sepsis screening: The Trust screening level sits at approximately 60% which is lower than required. A functioning dashboard is now in use. A recent audit has identified work required to ensure appropriate recording. This is underway, with Junior Doctors in particular, to educate the on sepsis screening and increase their involvement in associated improvement projects.
- Stillbirths: There were six stillbirths in August. All have been discussed at the September Board, where it was noted that they had been reported to the Care Quality Commission, the Local Maternity Service and the Trust's Commissioners. All cases have been subject to review and internal escalation processes have been enacted. Whilst no common themes were noted, work is ongoing to understand any issues.

The Academy discussed in detail the he continued issues around the reporting on medicine reconciliation and noted the work underway with the EPR team to identify how this can be automated.

9. Infection, Prevention and Control (IPC) Report Quarter 1

The Academy discussed the thorough report on progress against the IPC work plan for 2022/23 for the first quarter. The Healthcare Evaluation DATA (HED) indicator dashboard was reviewed. It detailed the Trust's position for MRSA and MSSA Bacteraemia, Clostridioides difficile (CDI) and E coli in relation to the national position. The key items discussed included;

- BTHFT is equal to or below peers' median for CDI and E coli but above the median for MRSA, MSSA healthcare acquired infections, however, the reduction in MSSA cases since January 2022 was noted.
- There was an increase at BTHFT of CDI in June and July of CDI. A number of other Trusts had experienced the same. Detailed individual post-infection review investigations have been undertaken. Multi-disciplinary meetings have been held with lessons shared and identified actions implemented.
- All wards where a case of CDI had been identified during June and July have now undergone a deep clean. Cases have subsequently declined to normal levels for the year.

10. Internal Audit Update

The Academy was particularly pleased at the outcomes of the internal audits undertaken since its previous report in March.

- Quality Improvement and Oversight reported High Assurance

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The following three internal audits reported Significant Assurance

- Nursing Assessments and Care Plans – Follow Up
- IPC Board Assurance Framework
- Catering

The Academy has noted the positive assurances provided.

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 three items:

1. Falls With Harm The Academy appreciated the detailed presentation which allowed focus on the challenges and problems along with the positive changes and the continued engagement within all areas to address this area.

6. Quality Oversight and Assurance The model for Quality Oversight was introduced during COVID to ensure continuing assurance for Patient Safety during the pandemic. The report sets out a full range of safety indicators to ensure that quality of patient care is monitored and managed appropriately. It is extremely comprehensive with much detail provided as part of the appendices. The Academy particularly welcomes sight of the 'Good Catch' newsletter which is routinely circulated to staff and features learning from events.

10. Internal Audit Update The Academy would like to acknowledge the assurance provided by the recent internal audit reports and commends those staff and teams involved for the ratings received and their good work.

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

There were no matters to escalate to other academies however the issue of discharge management was raised at the QPSA following a discussion at the Finance and Performance Academy on the morning of the 28 September 2022. The QPSA noted the ongoing work within this area and where possible the early identification of patients for discharge to assist patient flow. The Academy noted that this would be considered as part of the 'Perfect Week'.

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 28 September 2022.