

Board of Directors			
Date	9 March 2023	Agenda item:	Bo.3.23.13

Report from the Chair of the Quality and Patient Safety Academy (QPSA) held 25 January 2023

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 25 January 2023		
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	For assurance		
Previously discussed at/ informed by	QPSA held 25 January 2023		
Previously approved at:	Committee/Group	Date	
	N/A		

Key Matters Discussed

A summary of the key items discussed at the meeting held in January 2023 is presented below. Beside each title (where applicable) you will see a bracketed code which links to the key areas of work that underpin the delivery of the strategic commitments. The table appended to this report (Appendix 1) details the strategic commitments relevant to this Academy and those reported on at this Academy. Appendix 2 provides oversight of the reporting to all Academies with regard to the Strategic Commitments.

The confirmed minutes from the meeting will be available at Board in March 2023. The next meeting of the QPSA is scheduled for 22 February 2023.

Overview of key items discussed at the QPSA (Learning and Improvement) meeting.

I would like to share that the Academy formally expressed its deep sadness on the sudden passing of Dr Paul Southern. The testimonies shared were incredibly moving and it was so clearly obvious that Paul will be missed by both colleagues and patients alike.

I would like to mention that this was the last meeting for Professor Janet Hirst, Joint Chair of this Academy whose support and guidance has been invaluable over the last year – Janet retired at the end of January 2022.

1. Serious Incident Report (focus on learning)

The focus placed on the improvements to the reporting time frames for a number of investigations was helpful to the Academy. The Academy also noted the challenges as a result of capacity and capability within the Quality Team were being addressed following the recruitment of new staff and the implementation of training programmes to support their development. The Academy did note that it remained the case that actions were immediately implemented where required following an incident and the learning shared. The Academy also confirmed that it was helpful to the Academy that the HSIB commentary was now presented separately (due to the length of time it took for the conclusion of their investigations) - as this had a significant impact when considering all reporting time-frames. The key point from the discussion was that an action plan was

Board of Directors			
Date	9 March 2023	Agenda item:	Bo.3.23.13

developed and implemented immediately with the learning also shared in those early days - rather than teams awaiting the issue of the final report.

From the discussion held the Academy confirmed it was assured with regard to the actions undertaken.

2. Learning from Neonatal Unit Serious Incidents and Assurance from Neonatal Unit Serious Incidents

Thirteen new nurses had been added to the team which meant that this area was practically at full establishment and boded well for improvements to the standard and level of care. Discussion focussed on the resources and innovative approaches that had been put in place in the last two years for the neo-natal team in response to the distressing events that had taken place. The Academy noted the deep dive session that had taken place on the previous day where NEDs and Governors had the opportunity to hear in detail about the changes and their impact within Maternity Services. Whilst there had been some progress with regard to the laboratory actions - in particular with regard to 'FBC sample failures'; this area was still a cause for concern and the Academy has requested that further assurance is provided on this at the next Academy meeting.

3. Learning from Maternity Health and Safety Investigation Branch Reports

The Academy noted the presentation delivered and again referred to the deep-dive session delivered to NEDs and Governors on 24 February. The Academy was suitably assured from the update provided.

4. Palliative Care Annual Report

An excellent overview of the work of the Palliative Care Team was received and the Academy commended the team on winning the 2021 Nursing Times Workforce Team of the Year award. The team was described as remarkable by a senior colleague at the Academy who detailed an incident involving the Palliative Care team - demonstrating a great degree of respect for their experience and autonomy in the support, care and management of a dying patient who had presented at Accident and Emergency. The Academy confirmed it was assured with regard to the work undertaken in year by the Palliative Care team,

A detailed discussion also took place with regard to the RESPECT form. Here, frustration was expressed with regard to the pace of change in resolving the issues previously reported with regard to EPR. The Academy has requested that the Executives look at how priorities are set and provide a report back (on all priorities) to the Academy within the next 8 weeks.

5. In-patient Survey Adults 2021 (Pat 2b, Pat 2c)

The Academy noted the predominant profile of those who completed the survey (older, white and British) and, that the survey had been conducted during the pandemic. The improvement programmes in place with regard to the key themes identified cover:

- Bed waits and patient flow
- Help with mealtimes
- Communication
- Discharge planning and advice.

The Academy requested further key information in particular in relation to mealtimes and communications. In particular, the Academy was keen to understand the metrics in place covering meal times and, understand more around the area of communications, in particular with those whose first language is not English and, if this should be formulated into a risk for the Trust.

Board of Directors			
Date	9 March 2023	Agenda item:	Bo.3.23.13

An update on this is expected at a future Academy meeting.

6. Children and Young People Patient Experience Survey (Pat 2b, Pat 2c)

Whilst the response to the survey was not good the team had identified key areas from the feedback provided. The big issues highlighted were food and Wi-Fi. The team had developed a new child-friendly menu, in consultation with the patients themselves. Whilst it was at odds with dietetic services due to the inclusion of certain items, the response of the young people had been good. The Academy was keen to hear more and would look forward to further feedback on this which it was informed would be provided by Estates and Facilities at a later date.

7. Outstanding Theatre Programme (Pat1b, Pat3b)

The Academy received an excellent presentation and was particularly keen to note that the improvements were being staff-driven involving different staff groups and all grades. It was noted however that this kind of collaborative approach takes time and patience as this also speaks to changing the culture and behaviours to support sustained improvements.

The Academy is keen to hear more, particularly in relation to the overall strategy with regard to how the improvement programmes fit together, and how the Trust will manage the 'closure of the programmes' but maintain the learning.

8. Infection prevention and Control quarterly progress report (Pat 1a)

The Academy noted the risks identified mitigations in place and approved the actions. It confirmed it was assured by the reporting provided.

9. High Level Risks

The Academy noted a new risk, 3823, had been added; related to the Mortuary and the upgrade needed due to the age of the facilities.

Four risks had changed in score (one had risen and the remaining three had reduced in score).

The risk that had increased (3732) had moved from 15 to 20 and concerned midwifery and staffing levels. The Academy referred to the discussion that had taken place that morning at the People Academy and was sighted on the high rate of sickness in the Trust during December 2022 and January 2023 - more so in general nursing than in midwifery - however, whilst the Academy was assured that effective mitigations were in place to maintain safe staffing levels and that there was no indication of harm, there has been an impact on patient experience during the previous six to eight weeks.

One other risk was also flagged; risk 3671 related to the operational pressures being driven by Covid, Flu and other winter pressures. The Trust was now operating under OPEL (Operational Pressures Escalation Level) 3 (set by NHS England) whereby, 'the local health and social care system is experiencing major pressures compromising patient flow and continues to increase'. The Emergency Department (ED) was not now under as much pressure as that experienced over late December/early January, however, the Executive Team Management had determined that this risk should remain at 20 with the caveat that short-term pressures would fluctuate on daily basis.

Further, as mentioned previously the Academy was expecting an update at a future meeting on any potential risk regarding communications.

Board of Directors			
Date	9 March 2023	Agenda item:	Bo.3.23.13

Overall there was agreement amongst the Academy that the mortuary risk should align with the Quality and Patient Safety Academy. There was positive news with regard to those risks that had reduced in score and 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. Quality Improvement Programme Update

We very much welcomed the visit to the Academy by the Trust's Effectiveness and Quality and Patient Safety Manager, who provided an exceptional update on Quality Improvement in relation to learning, improvement and the provision of assurance. The focus on storyboarding was particularly insightful and the Academy was pleased to hear of the planned development of a library of storyboards.

HIGHLIGHTS

As Chair of the Academy, I would like to highlight from this month's meeting the following three reports received as exemplars of the learning and improvements taking place at our Trust.

- 7. Outstanding theatres service presentation
- 4. Palliative care annual report
- 10. Quality Improvement Programme update

Matters escalated to the Academies or Board of Directors for consideration

There were no matters for escalation to the Board or other Academies.

New/emerging risks

The Academy discussed a potential risk around language/communications, and an update will be provided at a future meeting.

Recommendation

The Board is asked to note the discussions, outcomes and where indicated the assurance provided from this meeting of the Quality and Patient Safety Academy held on 25 January 2022.

Board of Directors			
Date	9 March 2023	Agenda item:	Bo.3.23.13

Appendix 1

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

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	Pat1a - Implement Nursing & Midwifery, AHP and Clinical Risk Management strategies with focus on Leadership, Education & Development, Patient Experience, Staff Experience, Partnership Working and Quality & Safety of Care
	Pat1b - Senior staff to be empowered to resolve key issues and develop services
Pat2 - Providing outstanding patient experience	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	Pat3b - Support for clinicians to implement specific programmes of improvement