

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 22 February 2023

<b>Presented by</b>	Mohammed Hussain, Non-Executive Director, Academy Chair		
<b>Author</b>	Jacqui Maurice, Head of Corporate Governance		
<b>Lead Directors</b>	Karen Dawber, Chief Nurse / Dr Ray Smith, Chief Medical Officer		
<b>Purpose of the paper</b>	To provide a summary of the discussions and outcomes from the QPSA held <b>22 February 2023</b>		
<b>Key control</b>	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		
<b>Action required</b>	For assurance		
<b>Previously discussed at/ informed by</b>	QPSA held 22 February 2023		
<b>Previously approved at:</b>	<b>Committee/Group</b>	<b>Date</b>	
	N/A		

### Key Matters Discussed

A summary of the key items discussed at the meeting held in February 2023 is presented below. None of the items discussed at this meeting were specifically related to key areas of work that underpin the delivery of the strategic commitments.

The confirmed minutes from the meeting will be available at Board in May 2023. The next meeting of the QPSA is scheduled for 29 March 2023.

### Overview of key items discussed at the QPSA (Assurance) meeting.

#### 1. Quality and Patient Safety Academy Dashboard

There was a rich and detailed conversation held with regard to Falls, Pressure Ulcers and Sepsis. The Academy was reassured to note that work does continue to ensure consistency with regard to the data collected on Sepsis as this information is failing to provide an accurate picture of the position. The Academy appreciated the additional in-depth reporting on Mortality and the Standardised Hospital Mortality Index (SHMI) data and its comparisons to the year-end data. The Academy was suitably assured in the main however it would be keen to hear from Consultant Nicholas Rushton on SHMI at a later date and, to resolve the issues surrounding the collection of Sepsis data as at present there seems to be no reduction in the level of cases. The Academy has also noted that challenges still remain with regard to the collection of breastfeeding data however was reassured that Maternity Services continues to seek improvements in this area.

#### 2. Quality Oversight and Assurance Profile

The Academy noted from the volume of the documents provided the vast array of organisational learning that had taken place. In particular it was pleasing to read about the regional sharing of incidents and the sharing of learning across Place. A high level of assurance had been provided across the documentation.

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### 3. Serious Incident Report

The Academy was pleased to hear of the reduction in the average investigative time to 64 days and, that the team remained focussed on reducing this further. There was some confusion with regard to the reporting on 'breaches of the duty of candour'. Following discussion it was noted that this related to the standard for the timeframe for communications following an investigation where the Trust had reported 'no breaches' in this rather than no breaches overall. This will be clarified in future reporting with regard to the number of breaches and the Trust having met (or not) the standard for associated communications.

### 4. Complaints, Litigation, Incidents and Patient (CLIP) Experience Report (Quarter 3)

The Quality team provided an initial snapshot of data drawn from Datix on how incidents are affecting different ethnicities in response to a request by the Academy. The Academy welcomed this initial reporting however did note that the number of cases with 'no ethnicity' stated formed 20% of the total figure. The Academy was keen for the Quality team to analyse this information in more depth to find out why 'no ethnicity' was recorded and as such determine actions that could be put in place to ensure that ethnicity was recorded. The Academy also noted that as part of the next steps the Quality team would be looking at 'levels of harm' and analyse this data with the support of colleagues from the Equality Diversity and Inclusion team.

The Academy also queried the large number of 'open' cases on Datix which were from the previous year. Work to address these was underway as checks had revealed that action plans had been concluded and the loop had not been concluded in closing them down. This number was therefore expected to reduce as the verification work continued. It was also noted that 11% to date had been completed outside of the time frame and the Academy would look forward to further assurance being provided.

### 5. Patient Experience Interpretation Services – including risks relating to language / communication

The Academy would be keen to see proactive references to 'language' in reporting on issues as most papers were silent on this. Potentially there is an inequality and some of our communities may be more vulnerable. This may be a small risk but potentially the Trust might be missing something. Some references have come through on previous reports and the Academy has seen some maternity incidents specifically sighted on language as an issue. The Trust may be missing data on some incidents where it has not identified whether ethnicity or language was a factor. There is a risk if the data is missing as 'we don't know what we don't know'. In terms of adding 'language/communications' to the risk register, it is noted that this may well not score above 15 however the Academy confirms that it will be satisfied that the Chief Nurse adds a risk to her register and reports back on it to this Academy quarterly.

The Academy also referred to an issue that had been raised a while ago with regard to multi-lingual labels. The Academy noted that this would be revisited as colleagues at other Trusts had experienced some success where their populations were similar to our Trust.

### 6. High Level Risks

The discussion held at ETM regarding the risks was shared with the Academy which noted that;

- One new risk had been added to the register; Risk 3469: regarding the ReSPECT document and access to this on EPR. From previous discussions at the Academy it is known that this potentially impacts patients presenting at A&E. This risk has been on the register for four years however due to the ongoing difficulties on its compatibility with EPR (much of which has

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- been reported to this Academy in recent months) and it has now been increased to 15.
- Two risks had changed in score; 3411 had reduced 16 to 12 due to improvements in the vacancy level in Oncology and, similarly in Obstetrics and Gynaecology medical staffing (risk 3816) had reduced from 15 to 12 as a Urogynaecology Lead is now in post.

The Academy noted there were no risks beyond their review date and, that no risks had been closed since the previous meeting. The Academy also noted that there was one ongoing risk (3808) concerned with Strike Action. The target date was 31 January however this had now been put back to 31 March to reflect the ongoing situation.

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

## 7. Board Assurance Framework

The Academy was pleased with the way in which the report was presented. It was helpful and easy to understand. The Academy further confirmed that it was assured by the report.

## 8. Maternity and Neonatal Services Update

The Academy received the February update which related to the January activity. The key areas of discussion focussed on the Scan Capacity issue and the Academy noted that the team is currently focussed on mitigating the risk associated with this. An update on Saving Babies Lives v3 is due to be published shortly and the team will be sighted on the expectations in relation to scans.

Focus is also being placed on those women who have not attended their appointments and the Academy was assured of the actions taken to follow up immediately with these women following the clinics.

The Academy was pleased to hear about the new way of reporting to the Board that was being developed to streamline the information presented.

The Academy derived assurance from the comprehensive report presented.

## 9. 15 Steps Assurance Programme

The Academy sought assurance that the programme would include areas such as outpatients and not only wards. It was confirmed that this was the case. The Academy approved the programme and looked forward to receiving future reporting.

## 10. Internal Audit 2023/24 Planning Process

The Academy confirmed that it was content with the plan and had nothing further to add at present.

## 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.

- Quality and Patient Safety Dashboard - in particular the detailed reporting provided by the Chief Medical officer on SHMI.

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4. Complaints, Litigation, Incidents and Patient (CLIP) Experience Report (Quarter 3). It was pleasing to see the beginnings of the reporting on how incidents are affecting different ethnicities.
5. Patient Experience Interpretation Services – including risks relating to language / communication. The Academy is pleased that a risk will be added to the Chief Nurse Register.

#### **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**

There were no further new or emerging risks.

#### **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 22 February 2023.