

QUALITY AND PATIENT SAFETY ACADEMY (QPSA) ASSURANCE MINUTES

Date:	Wednesday, 28 th June 2023	Time:	14:00-16:30
Venue:	MS teams meeting	Chair:	Mr Mohammed Hussain (MH), Non-Executive Director/Chair
Present:	<p>Non-Executive Directors:</p> <ul style="list-style-type: none"> - Professor Louise Bryant (LB), Non-Executive Director <p>Executive Directors:</p> <ul style="list-style-type: none"> - Dr Paul Rice (PR), Chief Digital and Information Officer - Dr Ray Smith (RS), Chief Medical Officer - Joanne Hilton (JH), Deputy Chief Nurse - Adele Hartley-Spencer (AHS), Director of Nursing - Operations - Judith Connor (JC), Associate Director of Quality - Louise Horsley (LH), Senior Quality Governance Lead - Sara Hollins (SH), Director of Midwifery - John Bolton (JB), Deputy Chief Medical Officer/Operations Medical Director - Laura Parsons (LP), Associate Director of Corporate Governance/Board Secretary 		
In Attendance	<ul style="list-style-type: none"> - Nicholas Rushton (NR), Patient Safety Manager - Learning From Deaths - Chris Davies (CD), Deputy Director of Estates & Facilities - Jacqui Maurice (JM), Head of Corporate Governance - Liz Ward (LW), Named Nurse Safeguarding Children, Chief Nurse Team for agenda item QA.6.23.13 - Dr Jo Sims (JS), Consultant Paediatrician for agenda item QA.6.23.13 		
Observers	<ul style="list-style-type: none"> - Elizabeth Brooks (EB), Quality & Patient Safety Facilitator 		

Agenda Ref	Agenda Item	Actions
QA.6.23.1	Apologies for Absence	
	<ul style="list-style-type: none"> - Altaf Sadique, Non-Executive Director - Professor Karen Dawber, Chief Nurse - Dr David Smith, Director of Pharmacy - Sarah Freeman, Director of Nursing – Operations - Sarah Turner, Assistant Chief Nurse Vulnerable Adults - Mark Holloway, Director of Estates & Facilities <p>Absent:</p> <ul style="list-style-type: none"> - Jon Prashar, Non-Executive Director - Sughra Nazir, Non-Executive Director - Dr Yaseen Muhammad, Director of Infection Prevention and Control - Dr Deborah Horner, Deputy Chief Medical Officer 	

QA.6.23.2	Declarations of Interest	
	<p>MH declared an interest in relation to agenda item QA.6.23.13, as he was involved with this Child Protection Information Service as part of his role with NHS England (formerly NHS Digital). There were no financial implications and no action was required.</p> <p>There were no further declarations of interest.</p>	
QA.6.23.3	Minutes of the meeting held on 24 May 2023	
	The minutes of the meeting held on the 24 May 2023 were accepted as a true record.	
QA.6.23.4	Matters arising	
	There were no matters arising from the minutes that were not already on the agenda. Verbal updates were provided at the meeting on the outstanding actions and these are reflected in the action log.	
QA.6.23.5	Quality and Patient Safety Dashboard	
	<p>RS advised that there had been very little change regarding the dashboard, but highlighted an upward trend in mortality data as reflected in the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI). A lot of work was underway in these areas, and RS suggested that HSMR is removed from the dashboard going forward. RS went on to advise that the Trust's crude mortality rates are significantly lower than expected, given the challenges regarding Bradford's population.</p> <p>Regarding SHMI; RS stated that the Trust's depth of coding is significantly less than other organisations, suggesting work to be done in this area. However it was agreed that there were no causes for concern regarding HSMR and SHMI, and a robust process was recognised in the Medical Examiner's (ME) office. RS summarised that the Trust's care is very good, but is not represented by HSMR and SHMI.</p> <p>There was a further discussion (providing clarity) regarding depth of coding. RS explained that the process a coder uses to pull data from the Electronic Patient Record is quite complex and more complicated than anticipated. RS noted that SystemOne would be helpful in assisting coders to getting the information they need. The Learning from Deaths team is already working on this.</p> <p>MH highlighted from the dashboard that the data on the number of SJR requests raised was very helpful. In addition MH commented that the C Difficile infection rate had a downward trend. A positive step made was that there were 12 side rooms on ward 7 now suitable for patients with C. Difficile.</p> <p>The Academy was assured by the dashboard.</p>	
QA.6.23.6	Quality Oversight and Assurance Profile	
	LH presented the slides shared with the papers on the Quality Oversight and Assurance Exception Profile. For the observers, LH	

	<p>highlighted the aim of the Quality and Patient Safety Academy, as depicted on the slides. LH also provided an overview of the Quality Oversight System, drawing the Academy's attention to various groups that feed in to the cycle.</p> <p>An overview of Safety Events from 1st April to 31st May 2023 was delivered. 32 safety incidents were reviewed by SEG in the period, with 6 escalated to QuOC and 4 safety incidents declared as serious incidents. LH identified the following themes and trends from the safety events:</p> <ul style="list-style-type: none"> • High doses of Lorazepam given to patients with mental illnesses. • Delays involving Home Care Pharmacy. <p>LH discussed external reporting and noted there had been delays in RIDDOR reports being submitted and highlighted that the external reporting data can be found in Appendix 5 provided with the papers.</p> <p>The 4 serious incidents (SIs) declared were shared in more detail, noting that SIs 2023/8370 and 2023/9519 are Healthcare Safety Investigation Branch (HSIB) investigations. LH shared that 9 SIs were closed between 1st April and 31st May, with the details of each highlighted on the slides. In addition, LH noted that there were currently 10 open SIs, which is a significant improvement on the previous position. It was also shared that there were very few further information requests received from the Bradford District & Craven Health and Care Partnership following submission, indicating a good standard of quality of the reports being produced.</p> <p>LH noted that the Central Alerting System (CAS) statuses were shared in Appendix 4, highlighting that there were 14 alerts issued between 1st April and 31st May, with 3 alerts requiring response. Details of the alerts requiring a response were shared. Actions relating to the ongoing CAS alert are tracked by the Safety Event Group to ensure they are completed by the deadline of 30th September 2023.</p> <p>Claims and Inquests were detailed in Appendix 6 with the current position being noted.</p> <p>Appendices 7 – 17 detailed the learning from internal and external sources. LH informed the Academy that feedback from the CSUs is being sourced to evidence local learning as a result of sharing from internal and external sources.</p> <p>LH asked the Academy to note the comprehensive set of reports that have been circulated to provide assurance of learning and improvement.</p> <p>MH queried if there were any explanations for the theme of pharmacy home care delays. LH clarified that the delays were understood to be around the process of delivery. JC commented on the importance of demonstrating that we're taking learning and being proactive in our improvements.</p>	
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	The Academy was assured by the Quality and Oversight and Assurance Profile.	
QA.6.23.7	Serious Incident Report	
	<p>LH explained that the Academy was asked to note the May 2023 report circulated with the papers for assurance. It was noted that the Trust is contractually obliged to adhere to the current SI framework during the transition to the Patient Safety Incident Response Framework (PSIRF) which is ongoing.</p> <p>LH provided detail of the current SIs noted on the report. It was noted that SI 2021/24499 had been completed; MH noted that the learning shared had a lot of detail and queried whether all of the valuable learning had been captured. LH explained that a number of actions had already been implemented due to the time elapsed since the start of this particular investigation.</p> <p>Regarding Appendix 1, MH queried whether a final column could be introduced to the layout to accommodate any final learning; LH noted that the team will look into this as it is already captured in the reports. Further to this, MH noted that the report showed some issues around capacity at place level, meaning some investigations were delayed. MH queried whether anything could be done to start investigations when stalled at this level. LH clarified that immediate actions are implemented where possible prior to investigations commencing. JC noted that often the reports shared cannot account for the most up to date data, due to papers being provided to the Academy a week prior to the meeting, it was noted that the report referred to May 2023 and the investigations had subsequently moved on.</p> <p>The Academy was assured by the Serious Incident Report.</p>	
QA.6.23.8	Complaints, Litigation, Incidents, Patient Experience (CLIP) Quarter 4 Report	
	<p>LH advised that the report was a culmination of 2 years of work from the team and thanked the colleagues that pulled the data together.</p> <p>The following highlights from the report were shared:</p> <ul style="list-style-type: none"> • New graphs will form part of the Q1, 2023/24 CLIP report. • 882 compliments received within the period of the report (examples given on page 31). • 411 complaints received within the period, a 17% reduction on the 2021/2022 data. • ED continues to receive the highest number of complaints. However, when considered against the number of attendances this is 0.048% (68) and a reduction on last year. • A reduction has been seen in the number of complaint responses taking over 6 months and in February and March this was zero. • 13,022 safety events were reported during 2022/23 and 97.9% were reported as no or low harm which demonstrates a positive reporting and learning culture 	

	<p>within the Trust.</p> <p>It was also highlighted that some work was being undertaken around the data reporting regarding different ethnicities, including some work being done with historic data to ensure more accurate information held by the Trust. This is to review the levels of harm and ensure no one is disproportionately impacted upon.</p> <p>LH noted the following concerns from the report:</p> <ul style="list-style-type: none"> • The top theme across all safety incidents was staffing with 9.4% (1229) safety events reported as having staffing related issues as a contributing factor. • The highest category where staff had been affected relates to violence and aggression towards staff with only 17.9% (60) noting clinical factors. • At the end of the financial year there were 2039 safety events open within Datix. <p>JC commented that there is more in depth analysis that can be done going forward regarding data triangulation and this will be progressed by the team.</p> <p>It was confirmed that a risk reported to the Health and Safety Executive under RIDDOR concerning boiler 2 had been escalated to Executive level, with all risks being addressed appropriately. MH queried whether the risk should be escalated to Board level, with it being noted that the incident would be discussed at People Academy which will then be fed in to the Board of Directors.</p> <p>There was a discussion regarding an issue noted in the narrative of the report concerning Datix from Bradford District Care Trust (BDCT) as these are submitted in batches not on an individual case basis. JC shared that this had been escalated to BDCT, where it had been found that there some issues regarding administration between BDCT and BTHFT that were being addressed.</p> <p>The Academy was assured by the CLIP report.</p>	
QA.6.23.9	High Level Risks	
	<p>RS presented highlights of the report circulated with the papers. It was noted that there are 12 risks aligned to the Quality and Patient Safety Academy. RS highlighted risks that have been closed and new risks that have appeared on the register.</p> <p>There was a conversation regarding risk 3767 – Lone Working Devices for Maternity Staff. PR noted that a new contract was awaited and advised he will follow up. He further advised that there had been some work done with a test group already.</p> <p>RS shared that risk 3671 had been closed as NHS England has stepped down the national NHS level 3 incident. This has been replaced by new risk 3877, regarding high demand in relation to Covid-19 backlogs and the ongoing impact on patient care.</p> <p>Regarding the nurse staffing elements of the report, JH clarified</p>	

	<p>that the overstaffing element is just for Children's Service, and recruitment and retention plans are shared at the People Academy. JH highlighted that there will not be a significant change in the number of nurses until September and October 2023, where there will be a new cohort of newly qualified nurses.</p> <p>The Academy was assured by the High Level Risks report.</p>	
QA.6.23.10	Board Assurance Framework	
	<p>LP provided detail of the 6 strategic risks aligned to the Academy as outlined in the report.</p> <p>JC commented that the Trust is moving to a new system to replace Datix, it was advised that existing data will be migrated to the new system.</p> <p>The Academy was assured by the Board Assurance Framework.</p>	
QA.6.23.11.1	Maternity and Neonatal Services Update	
	<p>SH presented the Maternity and Neonatal Services update for May 2023, detail was given as provided in the reports circulated. The Quality and Patient Safety Academy was asked to note the following:</p> <ul style="list-style-type: none"> • The contents of the Maternity and Neonatal (Perinatal) Services Update, May 2023. • The publication of the Maternity CQC inspection report. • The monthly stillbirth position as provided in the report, acknowledging that a review has identified no emerging themes. • The Neonatal Mortality Report, Appendix 2. • The Maternity SI position as illustrated in Appendix 1a. • 0 HSIB SIs declared in May. • No elements requiring sign off for the Maternity Incentive Scheme in the report. <p>It was clarified that 'Acorn' is a sub-group set up as part of the continuity of care team, specifically targeted at vulnerable women.</p> <p>There was a discussion on the analysis of the numbers of stillbirths. It was assured that there were no themes identified in any of the cases, nor were there any issues with practice. SH explained that next steps would be to try and identify vulnerable women at an earlier stage, rather than waiting for them to present to the service late on in pregnancy.</p> <p>LH queried whether there were any safety recommendations regarding one of the cases discussed in the report. SH explained that there were no immediate concerns regarding safety, noting that observations of the mother returned to causes for concern.</p> <p>The Academy was assured by the Maternity and Neonatal Services Update.</p>	

QA.6.23.11.2	Maternity Care Quality Commission (CQC) Action Plan	
	<p>SH explained that the final Maternity CQC report was received in May 2023. The outcome of the report found that although the final rating given was 'requires improvement', there had been significant improvements made in the well-led domain, having gone from 'inadequate' to 'good'. It was acknowledged that a good rating could have possibly been achieved in the safe domain, if it were not for repeated issues with medicines management.</p> <p>SH highlighted 2 key actions from the inspection, one regarding the processes in place for medicines management, and the other regarding the lack of medical cover for the Maternity Assessment Centre (MAC). However, it was noted that the service was pleased with the overall report, and progress was already being made towards the 'should do' recommendations.</p> <p>The Academy was assured by the CQC Action Plan update.</p>	
QA.6.23.12	Safeguarding Adults Annual Report	
	<p>JH presented the highlights of the report circulated with the papers. It was pointed out that the report tried to focus on the statutory responsibilities that the Trust has as an organisation around safeguarding, which colleagues may notice is different to previous reports:</p> <ul style="list-style-type: none"> • It was noted that there may appear to be a drop in referral numbers, however JH explained that this is reflective of the Trust being clearer around referrals. • Increase in patients with mental health diagnosis. Noted challenges in A&E department caring for those patients. • Multi-agency risk assessment conferences continue to increase. JH noted an increase in domestic abuse cases. • Funding for the Hospital Independent Violence Advocate (HIDVA) post expires in 2024. • Training for safeguarding is being developed, particularly looking at the type of activity within the training. • Opportunities for dual registered nurses. <p>JH acknowledged thanks for the safeguarding of adults and children's teams, and the safeguarding maternity teams. It was noted that some recent cases had been challenging across all wards and departments.</p> <p>The Academy was assured by the Safeguarding Adults Annual Report.</p>	
QA.6.23.13	Safeguarding Children Annual Report	
	<p>Liz Ward (LW) and Jo Sims (JS) joined the meeting to provide a presentation on Safeguarding children.</p> <p>LW highlighted that the two appendices circulated with the report consisted of the Workplan and Audit plan corresponding to the report.</p>	

	<p>LW drew the Academy's attention to a substantial increase in demand for Children's Safeguarding, noting that a business case was being developed to increase staffing levels. LW shared that the training offered is well-planned, covering a wide range of topics, but is also responsive to new partnership issues as they develop; such as learning from Child Safeguarding practice reviews.</p> <p>As with adult mental health attendances, LW noted an increase in Children's mental health attendances also, noting that the Mental Health Crisis Pathway is currently being reviewed.</p> <p>In relation to the Star Hobson case, it was noted that the service is sharing good practice every week with the Emergency Department, highlighting learning and what has been done well.</p> <p>JS shared that there are some concerns with EPR regarding its ability to communicate with other systems, highlighting that this is a risk with regards to safeguarding as concerns from other areas of the trust may not be documented in EPR. PR commented that there is a wider place based programme around integrated individual care records that has been ongoing for a number of years. PR assured colleagues that Informatics understood the requirement, and commented on the importance of encouraging colleagues to prioritise and resource it. PR shared that there is work ongoing between the Trust and members of local authorities, with updates brought to the Academy as it develops. MH thanked JS for raising the concern, referencing this concern as being part of the priority list for EPR.</p> <p>There was a discussion regarding the Child Protection Information Sharing (CP-IS) service, with JS informing colleagues that the purpose of this digital project is to enable checks on children attending a 'front door' service such as the Emergency Department and Children's Assessment Unit. JS shared that the service is looking into developing involvement in this and taking some further steps going forward.</p> <p>LW shared that with regards to improvement, the Service had taken part in the Audit for Royal College of Paediatrics and Child Health standards for Child Protection Medicals, meeting 99 out of 103 standards. Further improvements were highlighted, as depicted on the slides shared.</p> <p>To conclude, LW shared some assurances such as small numbers of missed concerns and continued increases in referrals, demonstrating that staff are recognising concerns.</p> <p>Additionally, JS provided some detail of reports that are being submitted to the Safeguarding Partnership, a Section 11 report and the streamlining of the Safeguarding Standards for the Integrated Care Board.</p> <p>The presentation was noted by the Academy.</p>	
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QA.6.23.14	Estates and Facilities Quarterly Report	
	<p>Chris Davies (CD) joined the meeting to present the Estates and Facilities Quarterly report. CD explained that going forward the Dashboard presented will be available to colleagues for information.</p> <p>CD noted that work was ongoing for the Portering Transformation Project, which will be presented to the Academy at a future meeting.</p> <p>The Academy was assured by the Estates and Facilities Quarterly Report.</p>	
QA.6.23.15	Learning from Deaths Update	
	<p>NR gave an update around the Summary Hospital-level Mortality Indicator (SHMI). NR briefly gave detail that SHMI shows the ratio of the observed to expected deaths, both in hospital and up to 30 days after discharge. Explaining that a value greater than 100 means that the patient group being studied has a higher mortality level than expected. NR clarified the importance of noting that SHMI is not an indication of avoidable deaths, or of the quality of care received.</p> <p>NR acknowledged concerns raised in previous meetings that the SHMI was appearing to be quite high in April 2023. NR shared the results of a deep-dive undertaken by the Learning from Deaths Team, depicted on the slides.</p> <p>NR explained that SHMI is separated in to two contributing figures, in-hospital SHMI and out-of-hospital SHMI. Graphs depicted demonstrated that the out-of-hospital figure was higher than in-hospital.</p> <p>In addition, NR explained that from the deep-dive it has been found that BTHFT improved in 2022 on the previous year, with crude mortality rates decreasing over the previous 12 months, as well as a lower rate than neighbouring Trusts within West Yorkshire. There was a clarification that crude mortality rates represent in-patient deaths.</p> <p>NR summarised with next steps as shown on the slides.</p> <p>JC added that the Trust is also required to provide assurance at place level, noting that some further work will be done to develop.</p> <p>There was also a discussion around present issues in how SHMI is calculated, with colleagues suggesting that this was partly due to how the Trust handles data and coding requirements.</p> <p>The Academy was assured by the Learning from Deaths update.</p>	

QA.6.23.16	Patient Experience and Engagement Strategy 2023-2028	
	<p>JH noted that the Strategy remained in draft copy (Appendix 2), with the opportunity for colleagues to provide comments due by 7th July 2023.</p> <p>JH provided an overview of the Patient Experience and Engagement Strategy as shown on the slides circulated. It was emphasised that the Strategy was developed to provide a simpler experience for staff and patients.</p> <p>JH asked the Academy to share feedback on the Strategy in its current form ahead of its approval at the meeting of the Board of Directors on 13th July 2023.</p>	
QA.6.23.17	Patient Led Assessment of the Care Environment (PLACE) Annual Report	
	<p>JH provided an update on the 2022 PLACE report. Following a pause due to the Covid-19 pandemic, this restarted in late 2022, with an 18% reduction in the number of Trusts participating due to challenges faced that winter.</p> <p>JH shared that improvement has been seen and areas for improvement were identified around disability and dementia. A Place Steering Group has been set up to monitor progression going forward.</p>	
QA.6.22.18	Any other business	
	No other business was discussed.	
QA.6.22.19	Matters to share with other Academies	
	There were no matters to share with other Academies.	
QA.6.22.20	Matters to escalate to the Board of Directors	
	MH confirmed that the RIDDOR case discussed at agenda item QA.6.23.8 needed to be made visible at Board Level.	
QA.6.22.21	Date and time of next meeting	
	26 July 2023 14:00-16:30	
	Annexes for the Quality and Patient Safety Academy	
	Annex 1 - Documents for Information	
QA.6.23.22	Bradford District and Craven Quality Committee (highlight report/minutes)	
	Noted for information.	
QA.6.23.24	Freedom to Speak Up Quarterly Update/Annual Report	
	Noted for information.	

QA.6.23.25	Nursing and Midwifery Staffing Data Publication Report	
	Noted for information.	
QA.6.23.26	Internal Audit Reports relevant to the Academy:	
QA.6.23.26.1	BH32 2023 Recovery of Services Post Covid-19 Report	
QA.6.23.26.2	BH34 2023 Ward Accreditation Report	
QA.6.23.26.3	BH35 2023 Serious Incidents FINAL Report	
QA.6.23.26.4	BH38 2023 Patient Safety: National Standards for Cancer Patients	
QA.6.23.26.5	BH39 2023 Patient Safety: Falls	
	Noted for information.	
QA.6.23.27	Quality Account 2022/23	
	Noted for information.	

ACTIONS FROM QUALITY AND PATIENT SAFETY ACADEMY – June 2023

Assurance Meeting Actions

Learning and Improvement Actions

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
QA23007	22.02.23	QA.2.23.4	Matters Arising Quality Strategy (Linked to Action ID – QA22035 (29.06.22) QA.6.22.14) The Quality Strategy will be brought to the QPSA in due course with final comments.	Associate Director of Quality	July 2023	29.03.23: JC advised that work was ongoing on the Quality Strategy. To update at the next meeting. 26.04.23: In progress. Conversations continue with organisational development and transformation colleagues. Meeting scheduled for the beginning of May to meet with the Executives to identify the direction of travel. 28.06.23: JC advised that the Quality Strategy was not yet approved, though meetings are ongoing to discuss the content.
QA23010	22.02.23	QA.2.23.5	Quality and Patient Safety Academy Dashboard Sepsis - The Academy discussed the continuing issues with the sepsis tile. PR agreed to provide an update going forward following the next scheduled meeting of the Cerner Special Interest Group where all Cerner using Trusts share intelligence and insight regarding their respective approaches to	Chief Digital and Information Officer	September 2023	12.06.23: PR to provide an update at the June meeting. 28.06.23: PR noted that conversations were ongoing with other organisations in relation to Cerner. RS advised that new NICE guidance on Sepsis had been released on 28.06.23 and the Sepsis Dashboard will be released in due

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			deriving benefits from using the system to best effect.			course. It was agreed that this will be reviewed over the course of the next cycle, and an update would be provided at the September meeting.
QA23017	26.03.23	QA.3.23.6	Serious Incidents Report (Focus on learning) ST to do some work with the local police on how the Trust can make improvements to their communication regarding vulnerable patients, bringing a report to the Academy in four months' time.	Assistant Chief Nurse Vulnerable Adults	July 2023	
QA23025	24.05.23	QA.5.23.6	Infection, Prevention and Control Report C diff reduction measures were discussed and Covid-19 prevention measures noting the Board Assurance Framework (BAF) IPC has recently been updated by NHS England. This information will be added to the next IPC report.	Director of Infection, Prevention and Control	July 2023	
QA23028	24.05.23	QA.5.23.15.1	Care Quality Commission Maternity Inspection Report The report and action plan will be discussed at the Moving To Outstanding meeting on 30 May 2023, with the action plan submitted to the Quality and Patient Safety Academy meeting in June and to the Board of Directors' meeting in July 2023 for further oversight.	Chief Nurse	July 2023	
QA23023	26.04.23	QA.4.23.11	Bi-annual Digital Report MH requested that the next digital report considers what the low NHS App take up may mean for the Trust in terms of virtual wards	Chief Digital and Information Officer	August 2023	



Bradford Teaching Hospitals

NHS Foundation Trust

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
			and digital inclusion. MH also requested that the next update includes reference to the Electronic Prescription Service (EPS), to understand if that is something that is on our road map, and if so, whether we can achieve it and, what the implications might be for other priorities.			
QA23030						