

Meeting Title	Board of Directors		
Date	16 November 2023	Agenda item	Bo.11.23.14

Committee/Academy Escalation and Assurance Report (AAA)

Report from the: Quality and Patient Safety Academy/Committee

Date of meeting: 27th September 2023

Key escalation and discussion points from the meeting
<p>Alert:</p> <p>There were no urgent issues that were raised at the QPSA that require immediate attention from the Board.</p>
<p>Advise:</p> <p>There are a number of areas where the Board needs to be aware of progress.</p> <p>SlIs</p> <p>The QPSA was advised that was some concern in regards to capacity to complete SlIs in a timely manner, with the number of the Trust led investigations currently requiring extensions rising from 3 to 5. Of the 15 SlIs in the last year 5 were completed within the 60 days, and 10 exceeded the target timeframe. The transition to PSIRF will remove the 60 day target.</p> <p>There are currently 14 SlIs, of which 5 are with HSIB. There were no SlIs concluded in August 2023.</p> <p>Communication difficulties</p> <p>There remains an ongoing and continuing theme of communication difficulties, from previous meetings. The need for clinical translators was highlighted in the Quality Account update.</p> <p>Maternity</p> <p>An overview of the SlIs was provided to the QPSA. It was noted that there were 3 occasions in August where the unit was assessed as needing to divert women to other units, but there was also no capacity at the other units. This impacted care of delivery.</p> <p>Consultant anaesthetist compliance with PROMT training was low at 66% and support from the senior leadership team was sought to encourage greater engagement.</p>

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Learning from Deaths

There was a deep dive into the SHMI mortality data as BTHFT is an outlier. The deep dive sought to test a number of hypothesis to better understand the SHMI data.

1. Patients are reluctant to come to hospital for treatment when they should and are unnecessarily dying in hospital
2. That we are discharging patients too early and they are dying in the community rather than in the hospital

The analysis does not support these two hypothesis. It is clear that even if crude mortality does not corroborate the SHMI data there is an issue of poor depth of coding at the Trust that needs to be addressed. The proposed rationale that the depth of coding is the root cause of the Trust's poor SHMI data needs further analysis to test and understand. We recommend that the Board maintains awareness of this issue and the action plan to address.

Patient Safety Group

The Patient safety Group minutes raised a concern around Moving & Handling assessment in EPR. A NED asked for this to be brought back at a future meeting for more detail.

Assure:

The QPSA conducted an Academy effectiveness review with all participants able to provide answers to questions on the work, effectiveness and performance of the Academy using Slido. These will be analysed and brought back to a future meeting for discussion. The same set of core questions have also been used by the other Academies.

The Improvement strategy was presented to the QPSA. This sets out the strategy for the Trust to become an outstanding provider of healthcare, research and education and a great place to work.

High level risks

3 new risks have been added to the High-Level Risk Register, these are:

3890 – There is a risk that due to a lack of ultrasound scan capacity, that the 72-hour timeframe for scans could be missed.

3598 – There is no policy to manage physical restraint and/or rapid tranquilisation in the children's ward, leading to a variation in care.

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3767 – There is a risk that BTHFT maternity staff in the community do not always carry or have access to lone working devices as per Trust policy. This risk has had its score of 16, move to 12 and now back to 16. Assurance was given that the procurement issues in regards to this have now been addressed.

There are 2 risks beyond their review date; 3877 and 3711.

Research at the Trust

A detailed update was provided on the Trust's research activity. The Decluttering (safely) for Safety was discussed following a question from a Non-Executive Director. Previous research has identified that time spent by nurses double checking may not actually reduce harm in itself and takes time away from other activities that could be beneficial. This approach was welcomed, but it was explained that the research is at an early stage and the findings will not be complete for some time.

Report completed by:

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27th September 2023