Bradford Teaching Hospitals
NHS Foundation Trust

QUALITY AND PATIENT SAFETY ACADEMY (QPSA) - LEARNING AND IMPROVEMENT MINUTES

Date:	Wednesday, 24 May 2023	**Time:**	14:00-16:30
Venue:	Microsoft Teams meeting	**Chair:**	Ms Sughra Nazir (SN), Non-Executive Director/Chair
Present:	**Non-Executive Directors:** - Ms Sughra Nazir (SN), Non-Executive Director/Chair - Mr Altaf Sadique (AS), Non-Executive Director **Executive Directors:** - Professor Karen Dawber (KD), Chief Nurse - Dr Paul Rice (PR), Chief Digital and Information Officer		
Attendees:	- Mr John Bolton (JB), Deputy Chief Medical Officer/Operations Medical Director - Dr Debbie Horner (DH), Deputy Chief Medical Officer/Consultant Anaesthetist - Dr Robert Halstead (RH), Consultant in Emergency Medicine/Associate Medical Director - Dr Padma Munjuluri (PM), Consultant Obstetrician and Gynaecologist/Associate Medical Director - Dr Harry Ashurst (HA), Consultant Anaesthetist/Lead Medical Examiner - Ms Judith Connor (JC), Associate Director of Quality - Ms Faye Alexander (FA), Head of Education - Mrs Joanne Hilton (JHi), Deputy Chief Nurse/Director of Nursing - Mrs Sara Hollins (SH), Head of Nursing, Midwifery - Mrs Sally Scales (SS), Director of Nursing/Programme Lead for Magnet - Mrs Kay Rushforth (KR), Associate Director of Nursing for Children and Neonatal Services - Dr LeeAnne Elliott (LAE), Consultant Paediatric Radiologist - Mr Kez Hayat (KH), Head of Equality, Diversity and Inclusion - Ms Caroline Varley (CV), General Manager, Chief Medical Officer's Office - Ms Liz Tomlin (LT), Head of Quality Improvement and Clinical Outcomes - Ms Louise Horsley (LH), Senior Quality Governance Lead - Mr David Smith (DS), Director of Pharmacy - Dr Yaseen Muhammad (YM), Nurse Consultant/Director of Infection, Prevention and Control - Ms Laura Parsons (LP), Associate Director of Corporate Governance/Board Secretary		

In Attendance	- Mr John Holden, (JHo), Director of Strategy and Integration, in attendance for agenda item QA.5.23.5 - Mr Naveed Saddique (NS), Service and Business Development Manager, Strategy and Integration, in attendance for agenda item QA.5.23.5 - Ms Helen Fearnley (HF), Lead Tissue Viability Advanced Nurse Practitioner, in attendance for agenda item QA.5.23.23.2 - Ms Liz Melsom (LM), Outstanding Theatre Service Improvement Lead, and Ms Carol Close (CCl), Outstanding Theatre Service Lead, and Dr Ben Wetherall (BW), Consultant Anaesthetist/Outstanding Theatre Service Workstream Lead, in attendance for agenda item QA.5.23.12 - Mr Nick Rushton (NR), Patient Safety Manager, Learning from Deaths, in attendance for agenda item QA.5.23.11 - Dr Kavitha Nadesalingam (KN), Consultant Rheumatologist/Clinical Lead, Getting It Right First Time (GIRFT), in attendance for agenda item QA.5.23.13 - Ms Abimbola Olusoga (AO), Clinical Pharmacist Team Leader - Ms Jacqui Maurice (JM), Head of Corporate Governance - Ms J Kitching, Minute-taker
Observers	- Ms Raquel Licas, Staff Governor - Ms Beth Penn, Advanced Radiography Practitioner

Agenda Ref	Agenda Item	Actions
QA.5.23.1	**Apologies for Absence**	
	- Dr Ray Smith (RS), Chief Medical Officer - Mr Mohammed Hussain (MH), Non-Executive Director - Mr Jon Prashar (JP), Non-Executive Director - Mrs Sarah Freeman (SF), Director of Nursing (Operations) - Ms Jane Kingsley (JK), Lead Allied Health Professional - Mrs Adele Hartley-Spencer (AHS), Director of Nursing (Operations) Absent: - Dr Michael McCooe (MMc), Consultant in Anaesthesia/ Associate Medical Director - Ms Jill Clayton (JC), Deputy Associate Director of Nursing - Ms Joanna Stedman (JS), Deputy Associate Director of Nursing - Ms Kelly Young (KY), Deputy Associate Director of Nursing - Ms Marianne Downey (MD), Deputy Associate Director of Nursing - Ms Sarah Wood (SW), Quality Lead, Nursing and Midwifery - Mrs Sarah Turner (ST), Assistant Chief Nurse, Safeguarding - Ms Kay Pagan (KP), Assistant Chief Nurse, Informatics - Ms Caroline Nicholson (CN), Head of Non-Clinical Risk - Ms Leah Richardson (LR), Patient Safety Specialist - Mr Nazzar Butt (NB), Moving to Outstanding Lead - Ms Jacqueline Rigby (JR), Interim Associate Director of Nursing and Quality, Bradford District and Craven Health and Care Partnership	
QA.5.23.2	**Declarations of Interest**	
	There were no declarations of interest.	

QA.5.23.3	**Minutes of the meeting held on 26 April 2023**	
	The minutes of the meeting held on 26 April 2023 were approved as a correct record. The Academy noted that the following actions had been concluded: QA22059 – QA.11.22.91.1 (30.11.22) – Patient Experience – Six Month Report. QA23008 – QA.2.23.4 (22.02.23_ - Matters Arising (Discussion of the Bristol Insight Model (Linked to Action ID – QA22067 (14.12.22) QA.12.22.14) QA23019 – QA.4.23.5 (26.04.23) – Quality and Patient Safety Academy Dashboard. QA23020 – QA.4.23.5 (26.04.23) – Quality and Patient Safety Academy Dashboard. QA23021 – QA.4.23.6 (26.04.23) – Quality Oversight and Assurance Profile. QA23022 – QA.4.23.11 – Bi-annual Digital Report.	
QA.5.23.4	**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 and closed actions and these were reflected in the action log. In response to a request by KD, the Chair agreed that the Academy would discuss agenda item QA.5.23.23.2 – Pressure Ulcer Update presented within the 'For Information' section on the agenda. ..	
QA.5.23.5	**Update on Health Inequalities (HI)**	
	JHo and NS were welcomed to the meeting to provide an update on Health Inequalities (HI), with HI being the responsibility of each employee and JHo's team co-ordinating, sharing and encouraging participation. HI are systematic, avoidable and unjustified difficulties in the health and wellbeing of the population. The overlap with quality, diversity and the inclusion agenda was noted but each issue remains separate when considering socio-economic groups around deprivation. NS discussed the aims of the HI programme describing the five focused work streams and the findings from discussions with Clinical Service Units (CSU), publications, Corporate Strategy and Core20Plus5, approved by the Equality and Diversity Council. The work and progress across the Trust was presented including the developing communication activity underway with the CSUs in raising awareness of inequalities and establishment of community partnerships and the development of the intranet pages. JHo described the fantastic work ongoing across the Trust in terms of health and wellbeing of population and tackling inequalities and the conversations with different teams around access, outcomes and experience with some of this work having been presented to the Board of Directors regarding waiting times, outcomes and experience in Haematology, Dermatology, Children's and the	

	Urgent Care Centre. Staff currently signpost patients to relevant local agencies and services, going beyond the typical role of the acute hospital and taking the opportunity to address some inequalities by giving direct frontline support. The next steps were noted by the Academy as the Trust becomes an anchor for the community with the opportunities highlighted for the corporate teams, including the sourcing of funding through charitable funds for all populations. The imminent rollout of training options for staff in health inequalities and Core20Plus5 was noted to ensure full understanding via the standards framework. Health Equality Assessment Tool (HEAT) training is provided to support staff and the iterative approach with Healthcare Partnerships (HCP) and population health data to ensure the right information is obtained by teams working with data analysis and business intelligence teams at the Integrated Care Board (ICB), to source the right information. JHo and NS were thanked for the helpful insight noted by the Academy. SN noted the slicing down of the work captured in terms of access, outcomes and experience, referencing the successful work being undertaken in Maternity. KD noted healthcare organisations are asked to make every contact count and suggested some form of information pocket aid/guide as a reference for frontline staff, as a pointer for assistance to information. JHo acknowledged the importance of sharing best practice referencing the work ongoing in Maternity and Children's, and the provision of toolkits, which are extremely helpful to staff to have that conversation in order the Trust ensures every contact counts. NS noted the Core20Plus5 training covers health inequalities in general and the health equity assessment tool, a guide on how to use the service. The Trust is looking at the integration of this with the Trust's learning system to avoid unnecessary additional staff training. KH noted there may be an opportunity for himself and NS to link with the CSUs to raise awareness on Equality, Diversity and Inclusion (EDI) and HI and this was welcomed by the Academy. PR commented on the work underway with systems in relation to the mobile infrastructure over the next 18 months, including a limited number of Apps being introduced to assist with the strategy, ensuring staff have the specific relevant resources for their role within this city to provide information to the community. SN referenced the excellent suggestions in terms of QR codes and the further work to be undertaken as a team to address some of	

	these issues, noting work is undertaken on a 'business as usual' basis with the need to capture and share the work, in order to ensure best practice throughout the Trust.	
QA.5.23.6	**Infection, Prevention and Control (IPC) Report – Quarter 4 2022/23**	
	YM provided the Quarter 4 update on IPC, January to the end of March 2023, this being the fourth of four reports compiling the annual report. The rolling twelve month data was described in detail. The latest information available on Healthcare Evaluation DATA (HED), in relation to infection rates was noted showing the Trust's position for MRSA and MSSA bacteraemia, Clostridioides difficile (C diff), Klebsiella, Pseudomonas aeruginosa and E coli bacteraemia, in relation to the national distribution for each of these infections as of March 2023. The position of Bradford Teaching Hospitals (BTH) NHS Foundation Trust in relation to both national and regional data was noted with Bradford performing better than most other Trusts in the region for all rates. YM clearly described the targets set for each infection for 2022/23 against the actual, with only C diff and E coli bacteraemia being only very slightly outside of these targets. MSSA and MRSA bacteraemia had no targets; Klebsiella and pseudomonas were both under target. Analysis of the statistics was noted and the definitions for healthcare associated infections relating to Healthcare Onset Healthcare Associated (HOHA) and Community Onset Healthcare Associated (COHA) were described, noting the issues around justification. An explanation of the Healthcare associated HOHA and COHA figures were presented regarding BTH attributed infections. The 2021/22 and 2022/23 figures were compared with action plans in place as appropriate. 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. Compliance monitoring of assessment is voluntary, however, the Trust has a monitoring process for itself. The other IPC initiatives were noted. The IPC team are seeking to create a culture where IPC is part of each hospital team, assisting with good practice. The team now recognise areas of excellence, with certificates, where 100% compliance of achievements is evidenced. SN thanked YM for the very detailed and comprehensive report of data noting the evidence provided describing the turnaround of some infection data and an upturn in others over the winter period.	QA23025 Director of Infection, Prevention and Control (YM)

	SN noted in the C diff improvement action plan where a couple of actions scheduled for completion in November and December 2022, linked to the Electronic Patient Record (EPR) and hand hygiene audits, remain open. YM noted the actions, if not completed were either ongoing or not completed due to EPR issues awaiting finalization. The team await the forthcoming new technology and improvements, and once the updates are complete, the action plan will be updated. These have been left open deliberately as a reminder, as solutions continue to be identified. The report provided assurance to the Quality and Patient Safety Academy by monitoring the activity of the infection prevention and control annual work programme confirming the actions arising from the recommendations identified are appropriate.	
QA.5.23.7	**Patient Experience (PE) (Bi-annual report)**	
	JHi presented the highlights of the Patient Experience (PE) bi-annual report to the Academy referencing the detailed accompanying report. The highlights and the learning were described: • Successful year with thanks to the PE and CSU teams for the ongoing positive work around PE. • The PE group reports on a monthly basis to the Academy via the Patient Experience Group paper. • The PE Strategy embedding kindness project continues. • Acknowledgement that the Spiritual, Pastoral and Religious Care (SPaRC) team continues to improve access to the App ensuring support is offered to both patients and staff across the organisation. • Improved handling, processing and learning from complaints, capturing and sharing of compliments. • Continued participation in action plans from national surveys. • Restart of Voluntary services post-Covid, making a significant difference to patients and staff within the organisation. Positive feedback received from patients who have accessed the service. A new logo has recently been identified for volunteers. • There is now a Veteran Lead within the Trust and Silver Veteran accreditation has been received. • Various initiatives alluded to, both completed and underway within CSUs. • Engagement work around Maternity voices partnership. • Focussing on the launch in summer of the Patient Experience and Engagement Strategy and continued engagement with patients. • Improvements in comparison data concerning formal complaints noting a decrease in the numbers, with a focus around the engaging with complainants often resulting in earlier closure. • Increase noted in Patient Advice and Liaison Service (PALS) issues is a positive and significant change. • Positive examples discussed of learning from complaints particularly around examples shared with the Equality and Diversity Council. • Wider sharing and embedding of lessons learned into induction	

	and training. • Elements illustrated around the National Patient Safety Strategy and the ongoing work with patient safety partners, linking the findings and outcomes from the Worry and Concern Task and Finish group. • Revamp of patient bedside information and the Visitors' Charter. • Focus on Quality Priority 3, improving the patient experience by advancing the Equality, Diversity and Inclusion (EDI) agenda. • Challenges noted regarding data collection with the work underway with the new supplier for the Friends and Family test and healthcare colleagues discussed to ensure the development of meaningful data from the PE dashboard to understand and act on feedback promptly. Assurances were described with the focuses for 2023/24 noted which include wider engagement with the community and communication with a variety of service users to understand their needs. KD thanked JHi and Ruth Tolley, Quality Lead for Patient Experience, for the concise report noting the long-term gaps experienced by the team and referencing the work undertaken by the Directors of Nursing, their Deputies and the Matrons. This report has been moved from being driven from a central Corporate function to being embedded throughout all CSUs. KD acknowledged the reduction in the number of formal complaints, the increased use of PALS and noted the step change with opportunities and the chance to work differently in the months immediately post-Covid. SN noted the cultural shift from this being a defensive discussion to being very open, welcoming and acknowledging these learning opportunities. The enhancement of the bereavement service and link with the relatives' line was noted and the additional work, due to the Trust's population, around timely burials, which is 'business as usual' for the organisation, making a huge difference to families. SN also raised the issue of the Accident and Emergency waiting times, understanding the pressures but also the excellent focussed work overall. KH discussed the involvement of the EDI team where themes are identified, for example within complaints, looking at the impact and learning which is proving really effective when engagement is undertaken and patient case studies are presented to frontline staff. The Academy was assured by the report.	
QA.5.23.8	**Clinical Audit Annual Report**	
	LT reported on the Clinical Audit and Clinical Outcome annual reports with the purpose of the group to provide assurance to the Academy that the Trust is delivering the safest and highest quality of care based upon evidence, national standards and the relevant guidelines in order to implement best practice. A summary of the	

Trust's performance and progress against the High Priority Clinical Audit Plan for 2022 and 2023 was noted.

The Academy noted the continued focus by the Associate Medical Director for Clinical Outcomes and the Clinical Outcomes team to support the Clinical Service Units (CSU) and clinicians to ensure robust systems are in place to monitor and review progress against the mandatory national audit programmes as set out in the Quality Accounts List. Progress is monitored by the Clinical Outcomes Group of the risks and issues as set out in the Terms of Reference which includes:

- High Priority National Clinical Audit Programme.
- National Institute for Health and Care Excellence Guidance implementation/compliance.
- New services and/or procedures.
- Local clinical audits.
- Commissioning for Quality and Innovation.

An overview of presentations presented to the Clinical Outcomes group was noted along with the aims for assurance purposes, demonstrating the work across the organisation to demonstrate learning and improvement.

The Trust is duty bound to report any outlier reports that are received and there have been two in the last year, one around the Emergency Laparotomy audit. Following investigation with the Learning from Deaths team, reassurance was provided from the Structured Judgement Reviews (SJR) and review of data, with nothing of particular concern around the quality of care delivered to patients. Notification had been received from the National End of Life Care audit, concerning a complaint, however, no further concerns had been identified following a detailed investigation. Aims concerning best practice have been disseminated and further opportunities for sharing learning and improvement and the dissemination of information are being considered.

The clinical audit and introduction of new clinical procedures and techniques policies have both been reviewed and updated with no new clinical procedures reviewed this year. Ratification for clinical guidance, pathways and some work with the blood transfusion group, other Policies and Standard Operating Procedures were referenced and the group acknowledged the detailed assurance provided within the paper.

The Trust participated in all eligible national clinical audits, 29 out of a total of 42, included in the NHS England Quality Accounts list 2021/22 and all eligible national confidential enquiries.

The development of the clinical audit handbook for junior doctors to improve the quality of clinical audit and quality improvement projects is underway. Dissemination methods of communication are being refreshed.

LT noted the busy year ahead in continuing the improvement work.

	The Academy noted the content of the report and approved the Clinical Audit Annual Report for 2022/23. LT was thanked for the update.	
QA.5.23.9	**Clinical Audit High Priority Plan 2023/24**	
	The Clinical Audit High Priority Plan was noted for 2023/24 by LT, with participation required as part of the Quality Account. Fifty-nine out of seventy-four eligible audits are scheduled to be undertaken and improvements are being made with regard processes and assurance by the regulation team within the Quality team. A tracker is being re-introduced to manage and monitor compliance against national clinical audit recommendations, to confirm recommendations are being met. Progress will be considered around improvements, for particular services related to clinical audits. Clear evidence will then be available both locally and from a central governance perspective. SN thanked LT for the update and the Academy approved the proposed list, with the suggestion that future Annual reports should reflect more broadly, not only the national clinical audit work and the confidential enquiry programme, but also should capture the local clinical audit work achieved and the commissioning requirements.	
QA.5.23.10	**Outstanding Theatres Service (OTS) Programme**	
	BW/LT/CCI presented the Outstanding Theatres Service (OTS) programme update. Highlights from the five work streams were described as presented at the last OTS Programme Board. BW discussed a recent Audit looking at Group and Save for laparoscopic cholecystectomies, considering the risk of haemorrhage which is rare but serious. The Trust currently requires two blood samples prior to the procedure, in order to ensure, prior to anaesthesia, blood is available in the laboratory should this be required during the procedure. A retrospective study was undertaken on patients who had received transfusions in the same year. Findings reported suggested Group and Save is not mandatory for elective patients but rather on a case by case basis preventing unnecessary delays in theatre cases, workload for the transfusion department and costs for unnecessary samples. Results will be discussed with key stakeholders in the Trust along with consideration of the approach to Group and Save within other Trusts of a similar size. Other theatre groups will now be reviewed to identify if Group and Save is required for improved streamlining of the service. SN noted the positive impact of the programme on patients and the workforce questioning whether there was anything identified/to replicate to assist the forthcoming Outstanding Pharmacy Programme. The OTS group meets with the outstanding family/colleagues to share any learning, to discuss, test and	

	collaborate on the work in progress and lessons learned. Key learning concerns the people involved in the service discussing ideas/issues from staff to reinforce their ideas for improvement. The second year of the OTS programme will embed the continuing learning to date working closely with the CSU to ensure that the good in the service continues. SN noted the very helpful visual representation of the issues/processes underway and the results. PR confirmed to the Academy another element/aspect on work alongside the Outstanding Theatre Programme to deploy a theatre anaesthetics and critical care module within Cerner. Due to the consequence of Airedale's confirmation of its decision to move to Cerner and Trust Board confirmation of the decision to extend the Cerner contract, as a consequence of some re-profiling by Executives within the capital programme for 2023/24, the team is now in a position to move this forward. LT and CCI can expect Information Technology colleagues to be in touch shortly to link to CSU expectations and ambitions to ensure aspirations are met, in a way to improve the ambitions of theatres, anaesthesia and critical care. The presentation was noted by the Academy.	
QA.5.23.11	**Learning from Deaths/Mortality Review Improvement Programme 2022/23**	
	NR presented a review of the developments of Learning from Deaths over the last year 2022/23. The Trust has previously used a screening tool to determine cases for the Learning from Deaths programme, however, over the last twelve months the process has matured with the Medical Examiner's Office now referring the incidents to the Learning from Deaths' programme. The key highlights of the report were noted: • High number of referrals over the last few months received by the Medical Examiner's Office. Dr Harry Ashurst, Lead Medical Examiner, has confirmed that the ratio of referrals to actual deaths seen by the Trust mirrors the data seen by other Trusts nationwide. • SJRs have been completed on around two-thirds of cases referred, with a number of cases having been referred to H M Coroner. A number of cases have been rejected for various reasons with the most numerous rejected due to hospital onset Covid-19 infections, following a piece of work undertaken by IPC and the Learning from Deaths' programme. • SRJs conducted over the last twelve months identified in approximately 79% of cases, patients received adequate to excellent care prior to death with adequate care noted as being patients receiving an expected level of practice with any concerns raised, appearing to focus primarily on the admission	

	and initial care phase of a patient's treatment or in the ongoing phase of care. Where overall care was deemed poor, cases in the first six months of the year were subjected to an independent Stage 2 SJR. In the last six months these cases have been reviewed at a Multi-disciplinary team (MDT) panel within the Mortality Review Improvement Group where all learning has been collated, discussed at the Mortality Review Improvement Group, reported quarterly in infragraphic reports and also through the Quality Account and updates provided to individual CSU's Quality and Patient Safety Groups via the Quality and Patient Safety facilitators. • Key learning points discovered over the last twelve months were alluded to. Areas of outstanding practice have been identified during reviews with numerous examples of excellent communication between staff, patients, carers and families, particularly with vulnerable patients such as those with learning difficulties or severe mental health illnesses. • The most difficult circumstances identified evidence of excellent bereavement support to families where burial or cremation within a specific period of time is required. • Prompt recognition of End of Life care for patients usually at the point of contact. Multiple examples noted of clinicians fast-tracking End of Life patients in order for them to be discharged to their preferred place of death. • The actual Palliative Care received by patients was noted as outstanding, particularly regarding pain management. • Early recognition of sepsis cases identified. • Needs addressed for severe mental health illnesses. • Areas identified for improvement through learning noted from mitigations put in place as appropriate. • Actions have been taken to try to mitigate the issues particularly within the Accident and Emergency Department out-of-hours. • An ongoing piece of work is currently being undertaken by Safeguarding to address some of the issues. • The SJR process was noted to be the mandatory part of Learning from Deaths with additional achievements described including the supportive and productive relationships with the Medical Examiner's Office. • Revamp of the Mortality Review Improvement Group over the last year to act as a multi-disciplinary panel. Cases are now submitted to MDTs with between 12 and 20 clinicians monthly. The incidents are reviewed live within the meeting with the MDT panel highlighting the learning and actions, ensuring a most effective system. The Covid-19 project is underway to identify any further learning outside of post-infection reviews through SJRs and participation in the National Emergency Laparotomy Audit (NELA). In all cases the quality of care has been assessed as good to excellent with some local learning identified for surgical and anaesthetic specialties. • An extensive review of deaths was undertaken in response to a high number of adult in-patient mortalities in December 2022, with the report looking at the causes of death and co-morbidities for adult patients and the quality of care. No cause for concern was found.	

	• All learning and improvements are discussed at the Mortality Review Improvement Group and escalated to the Quality of Care Panel meeting. • The achievements were noted including publication requested of an SJR process flowchart for The Royal College of Anaesthetists' good practice library with credit given to Bradford. • Presentation at the Consultants' Grand Round. SN thanked NR for the comprehensive review of achievements identifying a significant number of actionable insights as well as areas for improvement. KD noted the informative and excellent presentation. NR confirmed there was no pattern of the Trust documenting Do Not Attempt Cardiopulmonary Resuscitation (DNA CPR) for learning disability patients. It has been noted in vulnerable with learning difficulties, or mental health patients, successful collaborative discussions have taken place with family members, carers and hospital specialists. KD questioned the processes of Standard Hospital Mortality Indicator (SHMI) outliers and regional discussions. NR noted this looks at both in hospital deaths and at deaths up to 30 days post-discharge. Work is underway by MMc to separate that indicator looking at the in hospital indicator and the out of hospital indicator (30 days post-discharge). The in hospital indicator closely aligns to the Hospital Standard Mortality Ratio (HSMR). A meeting is arranged with Clinical Coding representatives around recording of patient activity. Closer liaison may be possible with the Medical Examiner's Office who will shortly be reviewing community deaths and will clarify the palliative coding part of SHMI, which may be impacting the out of hospital aspect and data from the Quality Department will be assessed. KD noted this issue has been flagged as a regional issue at the West Yorkshire Quality meeting, and requested results of the deep dive undertaken are brought back to the June Academy meeting to identify any specific areas. The Academy noted SHMI and HSMR are used as alarm bells; these do not necessarily reflect issues of concern. LT noted SJRs may not pick up issues around whether mental health has been documented on the DNA CPR documentation and questioned whether a specific audit was required, noting SHMI/HSMR data does not determine whether the Trust is delivering quality care which is identified though the SJR process. LT thanked NR and MMc who are working to cascade the Learning from Deaths information to the CSUs. This excellent care improvement work should be celebrated. The Academy was assured by the update provided.	QA23026 Patient Safety Manager, Learning from Deaths (NR)

QA.5.23.12	Quality Improvement (QI) Programme Update	
	LT noted the Trust's vision to Improve as One, underpinning the principles of leadership and governance, infrastructure and resource skills, workforce, culture and environment, with the patient noted to be at the centre of all work underway. The work across the organisation was described with the teams and the methods used to embed learning, improvement and assurance, leading to the development of the Quality Strategy and LT provided the highlights: • The QI team is supporting some larger scale change programmes across the Trust along with some small scale change activities, embedding capacity and capability and sharing the work from the Outstanding Maternity Service (OMS) and the OTS programmes. • The ambitious targets for the last year 2022/23 were described, in particular, the target of training 20% of all staff to Foundation Level QI training as clinical leaders; to date 55 clinical leaders have been trained as practitioners to be both involved in and to deliver QI projects. The resources used were noted. • Domains noted around the key pillars of quality which surround patient experience, patient safety, clinical effectiveness and staff experience, and how these fit within the Trust's framework of learning and improvement. These are underpinned by the NHS Patient Safety Strategy ensuring a continuous learning environment and patient safety culture with involvement from the Organisational Development (OD) team ensuring testing and roll out through the organisation. • Shared learning presented at events and via the QI Network. • Celebration of the work presented. • Live QI platform continues to gather all information in a central system. • Consideration of the approach to our improved priorities across the local system at place. Conversations underway with Education, OD and Transformation colleagues. • Team have delivered training to 611 people over the course of the year (16% of Trust staff). • Discussions with Trust colleagues to identify additional staff who wish to be involved in QI. • Targets for 2022/23 and Specific, Measurable, Achievable, Relevant, and Time-bound (SMART) key aims noted. • Setting up of a departmental training and mentoring programme for colleagues within the Accident and Emergency Department. • Active projects and activity over the last year regarding Life QI. • Improvement work illustrated against the Trust's strategic objectives and CSUs demonstrating the value and impact that the programmes are having. • Capacity and capability across the whole of the Trust under consideration around the Quality Service and redesign work, and engaging with the Transformation team around the Quality Service and redesign work. • Leadership work is being led by OD fitting in well with cultures and the quality management system.	

	PR commented regarding the opportunity for collaborative working with Airedale and the leadership team for each individual unit with an appropriate skill set and being keen to discuss the opportunities further with LT looking at key areas which would benefit. September 2024 is the go-live date for Airedale's EPR. The new opportunities were noted in Bradford supporting theatres, anaesthetics and critical care. SN thanked LT noting the number of opportunities which have been identified to collaborate outside of the meeting and the in depth detail reported. The Academy was assured by the presentation.	
QA.5.23.13	**Clinical Outcomes Group Meeting - Getting It Right First Time (GIRFT) Update**	
	KN and CV updated the Academy regarding the GIRFT national programme designed to improve the treatment and care of patients through in depth review of services, benchmarking and presenting a data driven evidence-base to support change. The key points were noted: • There have been 32 deep dives which have taken place at BTHFT since 2016. • Two national meetings have taken place this year, one a GIRFT Endocrinology Gateway Review for the West Yorkshire Integrated Care System and a GIRFT Virtual Model Health System review for paediatric surgery in Yorkshire and Humber. • The GIRFT team continue to present at various staff engagement meetings and meet with the CSUs for education purposes. • GIRFT deep dives undertaken in rheumatology, lung cancer and urology were discussed and recommendations noted have been actioned: <u>Rheumatology</u>: • Outcomes were good resulting in shorter working times due to increased staffing and triaging and as a result there has been an increase in out of area referrals. • Development of remote care pathways with Doctor Doctor. • In relation to reducing the overall Referral to Treatment waiting times there has been a key guidance document published in December 2022, for reference by specialty, Clinically-led Speciality Outpatient guidance, providing a number of recommendations in relation to out-patient services. • Patient initiated follow-up work is being promoted within teams. • The work to facilitate remote consultations through Doctor Doctor to streamline administration pathways will be rolled out soon. <u>Lung Cancer</u>: • Protected radiology appointment slots to reduce waiting times for some radiological examinations and weekly lists of abnormal results being received by the Lung Cancer nurses from Primary Care and the Trust. • Increased number of referrals noted into the lung cancer	

	service. Urology: • High Volume Low Complexity focuses on a reduction in the backlog of patients awaiting planned operations, improving clinical outcomes and access to services through standardised clinical pathways. • Consultation is underway where possible for some surgical procedures to be moved from in-patient to day case surgery. There are some limitations, however, when the new day case surgery unit opens up at St Luke's and it is envisaged the programme will commence roll-out and expansion. The presentation was noted by the Academy with SN commending the team for the helpful, detailed and insightful presentation.	
QA.5.23.14	**Serious Incident (SI) Report – April 2023**	
	LH discussed the key points of the SI report noting the extensive pack of papers accompanying the report. The number of outstanding serious incident investigation reports has continued to reduce. Concerns have been raised around some recent reviews by Bradford District and Craven Health and Care Partnership that some Trust SI reports are not clearly stating the support provided to staff, patients and relatives both following incidents and during the investigation process. Actions are in place to rectify this and the Academy was assured that despite this not being reflected in some reports support is always offered to these groups and the team have been recognised externally as part of the Learn Together Project for this work with the Trust having received an award for this. Concerning the launch of the Patient Safety Incident Response Framework (PSIRF), introducing different methods of investigating patient safety events, the pool of investigators is being expanded and staff have been invited to training sessions being provided at the Trust by Consequence UK. LH provided an oversight of the SIs including those declared, ongoing and concluded between 1 and 30 April 2023 noting, there has been a slight decrease in SIs over the last two months but reporting remained within normal variation: • One SI had been declared in the month of April, an HSIB (Healthcare Safety Investigation Branch) case: - SI 2023/8370 – HSIB investigation. Maternity patient with gestational diabetes suffered intrauterine death at term. The case has been reviewed and the immediate learning identified and circulated. - Ten SIs are currently at the investigation stage with one of these being led by Bradford District and Craven Health and Care Partnership and five of these being HSIB investigations. Six investigations are within the 60 day deadline of the current SI framework and four have received agreed extensions to the original deadline. • Six SIs were reported to have been concluded between 1 and 30 April 2023:	

	- 2022/22153 – Treatment delay. - 2022/23056 – Diagnostic incident including delay (including failure to act on test results). - 2023/632 – Abuse/alleged abuse of child patient by third party. - 2023/633 – Disruptive/aggressive/violent behaviour. - 2023/760 – Sub-optimal care of the deteriorating patient. - 2023/2397 – Adverse media coverage or public concern about the organisation or the wider NHS. • The lessons learned and safety recommendations were noted comprehensively in the report including: • Full knowledge of children's social care history with mental health issues ensuring the correct level of care and supervision is provided on admission. • The compilation of a welcome pack to assist external agencies caring for young people and children on wards. • Recognising deteriorating patients within out-patient settings and escalating to the appropriate care service, facilitating management and in an attempt to prevent further deterioration. • To clearly define the roles and responsibilities of nursing staff in the paediatric Accident and Emergency Department team identifying the processes around the management of children and to facilitate timely review by senior clinicians to inform a decision making around self-discharge. • Recent changes highlighted at the Health Care Partnership with twelve SI closure letters awaited. • There were no Never Events declared in the month of April 2023. • There were no Duty of Candour breaches during the month of April 2023 or since August 2016. SH thanked LH for the concise narrative. The Academy noted the report reflects a key control for the strategic objectives, to provide outstanding care for patients by embedding learning in line with the Academy's ethos of learning, improvement and assurance. The Academy confirmed there was sufficient assurance that the Trust has processes in place to identify, investigate and learn from SIs.	
QA.5.23.15	**Maternity and Neonatal (Perinatal) Services Update – April 2023**	
	SH presented the content of the Maternity and Neonatal (Perinatal) Services updated from April 2023 to the Academy. SH alluded to the findings of the Care Quality Commission Maternity Inspection undertaken in early 2023, where the mostly positive results are embargoed until 26 May 2023. The Trust's Maternity overall rating will be increased, however, the inspection did not impact on the overall rating for Maternity and this will remain unchanged. The area most pleasing concerns the well-led standard which is significantly improved. SH thanked SN for proof-reading the draft report following the comments/inaccuracies received.	

	The key activities relating to April were highlighted: • Appendices noted of all completed Serious Incidents, stillbirths and harms occurring during the month of April. • As part of reporting for the Maternity Incentive Scheme (MIS) Appendix 2 of the report, the Avoiding Term Admissions into Neonatal Units (ATAIN) and transitional care unit, Quarter 4 report was highlighted demonstrating compliance with Safety Action 1 of the MIS. • The Getting It Right First Time (GIRFT) Neonates recent review complemented on the management of ATAIN. • Review of babies in the last quarter: One baby was an avoidable admission on to the Neonatal Unit and could have been admitted to the Transitional Care Unit, four outstanding cases remain for review and further updates will be made if required. • The Maternity training and compliance quarterly report was noted as part of the perinatal quality oversight surveillance processes. The majority of the report is acceptable, however, a continued focus remains on mandatory training regarding delivering blood competences and review actions for ward and departmental managers to ensure individual compliance. • MIS – PROMPT emergency training has seen a decrease in compliance amongst some obstetric doctors due to the new rotation of General Practice trainees. A recovery plan is in place. • Work continues with anaesthetic colleagues re PROMPT emergency training to ensure compliance will be declared within the timescale. • April cases – Two stillbirths, one baby cooled, two Health and Safety Investigation Branch (HSIB) referrals, three neonatal deaths and one completed investigation. Recommendations, actions and progress on actions noted by the Academy. SN thanked SH for the detailed presentation and for the Academy's detailed pack of papers acknowledging the work involved in producing the appreciated papers. The Academy were assured.	
QA.5.23.15.1	**Care Quality Commission (CQC) Maternity Inspection Report**	
	Following a Care Quality Commission (CQC) inspection of the Trust's Maternity services in January, KD acknowledged the hard work from the Maternity team following receipt of the draft CQC Maternity Inspection report, noting the CQC has found improvements in Maternity services and the care provided to women and their babies, thus reflecting the hard work, dedication and compassion of colleagues. In comparison to other Trust's the Unit is well-referenced. With two 'Must do' and a number of 'Should do' actions, KD highlighted one of the 'Must do' actions around medicine management and the disposal of epidural bags after use. KD noted this is not a patient safety issue but as this was referenced as a 'Must do' in the last report, this is imperative. The report was hugely positively and complimentary to the	

	leadership team. An action plan will now be provide on the actions required by mid-June. 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. Unfortunately the deadlines do not allow sign off at the Academy or Board prior to submission.	QA23027 Chief Nurse (KD) QA23028 Chief Nurse (KD)
QA.5.23.16	**High Level Risks**	
	KD presented the high level risks aligned to the Academy, noting the changes since the last report which include a number of the risks on the Risk Register in relation to strike action having now been mitigated and which, therefore, will be removed. Risk 3863 – Fit Testing – This has been added to the High Level Risk Register. The risk scored 15 and is aligned to the People Academy. This risk has reduced in score as funding has been secured for additional fit testers and a route identified to manage this going forward. The health and safety risk will be ongoing over the next twelve months whilst staff are fit tested in line with the new national requirements. The Academy reviewed, challenged and assessed the identification and management of risks within their remit on the High Level Risk Register, noting the matters raised by the Executive team at a meeting on 15 May 2023. Assurance could be provided to the Board that all relevant risks are being managed appropriately and there were no issues in relation to the high level risks to highlight to the Board.	
QA.5.23.17	**Any Other Business**	
	There was no other business to discuss.	
QA.5.23.18	**Matters to share with Other Academies**	
	There were no matters to share with the other Academies.	
QA.5.23.19	**Matters to escalate to the Board of Directors**	
	There were no matters to escalate to the Board of Directors.	
QA.5.23.20	**Date and time of next meeting**	
	Wednesday, 28 June 2023, 2 pm to 4 pm	
	Annexes for the Quality and Patient Safety Academy **Annex 1 – Documents for Information**	
QA.5.23.21	**Quality Account**	
	Noted for information. JC drew the Academy members' attention to the Quality Account for which a number of very positive responses and comments to date have been received. JC reminded the Academy any comments should be submitted to her and JM at the earliest opportunity.	QA23029 (All)
QA.5.23.22	**Research Activity in the Trust**	
	Noted for information.	

QA.5.23.23.1	**Patient Safety Group**	
	Noted for information.	
QA.5.23.23.2	**Pressure Ulcer Update**	
	Noted for information. KD introduced HF to present the Pressure Ulcer Update to the Academy undertaken due to 219 hospital acquired pressure ulcers reported between January 2023 and April 2023, and noting the huge amount of work currently underway throughout the Trust. The current risk score is 16. The residual score is 6 once all mitigation is actioned. HF highlighted the key factors: • Meetings held over the last couple of weeks regarding the current position, the issues, risk assessments and necessary improvements and mitigations both in place and required. • Areas identified of concern where additional support is required along with a review of actions for the Trust. • Issues risen post-Covid as patients are admitted in a frail deconditioned state with patients having avoided healthcare due to the cost of living crisis impact felt by some individuals. • Skin assessments noted to have not been completed in a consistent or frequent manner. • Delays in obtaining/installing appropriate equipment. • Waiting time factors, for example in the Accident and Emergency Department. • Current methods of investigating pressure ulcers under review and themes of learning provided. Investigation time versus learning. • Patient choice - Conversations now involving other professions for example the mental health team, learning disabilities and dementia lead nurses. • Processes in place to monitor incidents and standards, for example via ward accreditation, spot checks, continued monitoring. • Good reporting via Datix. • E-Learning modules introduced, as developed by NHS England as part of the national Wound Care Strategy Programme, to add to existing learning measures already in place. • A new teaching model has recently been purchased. • Training provided to newly qualified nurses, Healthcare Assistants, with ward based bespoke training now delivered according to ward needs. • Ongoing preceptorship to support newly qualified nurses and new starters to the organisation. • Contract in place for equipment. • Tissue viability champions. • Equipment available as required. • Pressure ulcer awareness week arranged for November 2023. • Pressure ulcer conference is in the planning stages with a focus on practical issues for example, assessment with links to other services. • Safety care conference planned for June 2023, with a focus on	

	patient safety, to include pressure ulcers. The event will launch the deconditioning project across the Trust, Quality Improvement, successes and civility. • Opportunities for pressure ulcers within PSIRF implementation to assist with learning and improvement, investigation, governance and enhancing the care of older people. • Assurance factors and further actions were noted including the implementation of Purpose T and the utilization of Clinical Practice Educators and legacy nurses. • EPR pathways and e-learning continue to be developed. SN noted the very comprehensive presentation in terms of prevention, identification and management of pressure ulcers, highlighting this work should improve both patient experience and outcomes. The opportunities that PSIRF will provide, in the future, in terms of investigations and lessons learned was noted of interest. LAE discussed the huge amount of work in the Trust already undertaken around falls, frailty, equipment and risk assessment and questioned the opportunities for joining some of the learning together, particularly in relation to the introduction of PSIRF to improve the benefits for all. HF agreed to this opportunity with the exciting forthcoming work and was thanked for the presentation.	
QA.5.23.24	**Clinical Outcomes Group**	
	Noted for information.	
QA.5.23.25	**Patient Experience Group**	
	Noted for information.	
QA.5.23.26	**Quality and Patient Safety Academy Work plan**	
	Noted for information.	
QA.5.23.27	**Internal Audit Reports relevant to the Academy**	
	There were no reports.	

Bradford Teaching Hospitals
NHS Foundation Trust

ACTIONS FROM QUALITY AND PATIENT SAFETY ACADEMY – MAY 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	June 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.
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 deriving benefits from using the system to best effect.	Chief Digital and Information Officer	June 2023	12.06.23: PR to provide an update at the June meeting.

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
QA23024	26.04.23	QA.4.23.16	**Draft Engagement Strategy** A request has been received for the Draft Engagement Strategy to be deferred. The Academy will review the strategy at the June meeting.	Deputy Chief Nurse	June 2023	20.06.23: Added to the June agenda. **CLOSED**
QA23026	24.05.23	QA.5.23.11	**Learning from Deaths/Mortality Review Improvement Programme 2022/23** KD questioned the processes of Standard Hospital Mortality Indicator (SHMI) outliers and regional discussions. NR noted this looks at both in hospital deaths and at deaths up to 30 days post-discharge. Work is underway by MMc to separate that indicator looking at the in hospital indicator and the out of hospital indicator (30 days post-discharge). The in hospital indicator closely aligns to the Hospital Standard Mortality Ratio (HSMR). A meeting is arranged with Clinical Coding representatives around recording of patient activity. Closer liaison may be possible with the Medical Examiner's Office who will shortly be reviewing community deaths and will clarify the palliative coding part of SHMI, which may be impacting the out of hospital aspect and data from the Quality Department will be assessed. KD noted this issue has been flagged as a regional issue at the West Yorkshire Quality meeting, and requested results of the deep dive undertaken are brought back to the June Academy meeting to identify any specific areas.	Patient Safety Manager, Learning from Deaths	June 2023	16.06.23: Item added to the June agenda. **CLOSED**

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
QA23027	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	June 2023	16.06.23: Item added to the June agenda. **CLOSED**
QA23029	24.05.23	QA.5.23.21	**Quality Account** JC reminded the Academy any comments should be submitted to her and JM at the earliest opportunity.	All	June 2023	16.06.23: Item added to the June agenda. **CLOSED**
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	

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
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 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.	Chief Digital and Information Officer	August 2023	
QA23030						

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress