Meeting Title	Board of Directors		
Date	13 July 2023	Agenda item	Bo.7.23.8

Academy Escalation and Assurance Report (AAA)

Report from the: Quality & Patient Safety Academy

Date of meeting: 28 June 2023

Key escalation and discussion points from the meeting

Alert:

- The Academy wished to bring the Board's attention to a 'dangerous occurrence' incident was reported to the Health and Safety Executive under RIDDOR during this financial year (November 2022). This related to a fire/explosion of diesel fuel within boiler 2 in the boiler room at BRI in November 2022. A Level 1 investigation was undertaken, with a conclusion that potentially, this incident could have had more serious consequences for boiler engineer and the Trust. This remains a significant risk to the Trust and an update on the incident was provided to the Executive Team on 19 June. We were advised that the People Academy had been made aware of this incident via reporting from the Health and Safety Committee. It was noted that there is a risk on the high level risk register relating to backlog maintenance and critical infrastructure risk, which is scored at 20.

Advise:

- Sepsis – we noted ongoing issues with data quality relating to the sepsis screening figures. A new dashboard is in development and updated NICE guidance has been published. The Academy will receive an update on developments in September.

- Summary Hospital Level Mortality Indicator (SHMI) – a detailed update was provided following discussions at the previous meeting, where it was noted that the Trust's SHMI value was increasing. It is important to understand the context around the data and it was highlighted that SHMI is not an indication of avoidable deaths or the quality of care, but it serves as an early warning system so that any potential issues can be looked into. It was noted that the crude mortality rate is lower than expected given our population, and all deaths are subject to a review. Some issues were noted in relation to the depth of coding, action is being taken to understand and address this.

- Safeguarding adults annual report – we noted that there has been an increase in activity particularly around patients with a mental health diagnosis, and domestic abuse cases. All areas of the self assessment against commissioning standards were green with the exception of training and the inclusion of Prevent in Level 3 training, and the Child Protection Information Sharing (CP-IS) system, which will be subject to a compliance audit during 2023-24. We also noted that further templates will be developed in EPR to support the improved recording of decision

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making in relation to Deprivation of Liberty Safeguards.

- Safeguarding children annual report – we were alerted to ongoing issues relating to the integration of EPR with other systems. This was being considered at a Place level and the team were seeking to learn from best practice in other areas. This is an issue that will continue to be reviewed by the Academy.

- Electronic Patient Record (EPR) – a number of items inevitably referenced or had dependencies on the EPR, we have agreed previously for regular updates on the EPR priorities so these can be reviewed and aligned with ongoing or emerging requirements

Assure:

- We received good assurances on the quality oversight system, including the management of serious incidents (SIs). We sought additional assurances that learning is captured and implemented and that any delays are being appropriately managed.

- We considered the high level risks and the Board Assurance Framework (BAF), and were assured that risks were being managed appropriately and that all relevant risks were recorded. It was noted that a new system would be implemented to support incident recording and management. The new format for the high level risk report was also welcomed.

- Maternity – we noted a slight increase in stillbirths but were assured that appropriate measures are in place to review stillbirths and learn lessons. We will monitor closely at the next meeting for any uptrend.

- Maternity CQC – we were pleased to note the improvement in the well led rating for maternity services to 'good', and was assured that appropriate actions are being taken to address the recommendations.

- The draft Patient Experience and Engagement Strategy was introduced, we were supportive of this and it is included on today's board agenda for approval.

- Patient-Led Assessments of the Care Environment (PLACE) – an improvement had been seen across all areas but there were some areas of focus around accommodating the needs of patients with a disability or dementia. We noted that this is one type of assessment and the results are triangulated with other sources of intelligence, for example the ward accreditation and '15 steps' processes.

Report completed by:

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7th July 2023