

Meeting Title	Board of Directors		
Date	21 September 2023	Agenda item	Bo.9.23.11

Academy Escalation and Assurance Report (AAA)

Report from the: Quality and Patient Safety Academy

Date of meeting: 23 August 2023

Key escalation and discussion points from the meeting

Alert:

There are no urgent issues that the Academy needs to bring to the Board's attention.

Advise:

- *Two safety incidents were discussed.*
 - A discharged patient fell getting into their car and some staff were initially 'reluctant to take responsibility' (colleagues did then take patient to ED). We discussed personal responsibility and building staff confidence to act where safe. We discussed how to encourage staff to be 'active bystanders' across a range of situations. An action was set to consider the next steps.
 - Theft of Trust laptops and paper documents due to a break in at St Luke's constituting a data breach. There was a discussion around not holding paper records in laptop bags and smartphone options to support staff when working offsite, where opening a laptop in public is also a safety risk.
- *Two new high level operational risks were raised*
 - Regulatory and patient safety risks associated with pharmacy staffing levels and unfilled vacancies. Work within the Outstanding Pharmacy Services programme was discussed. The Academy recognised the complexity of the issue that is partly linked to national staff shortages, but as a high priority risk we were assured it is receiving significant focus.
 - Risk due to lack of operational security, management and resilience. This was briefly discussed as it sits with the People Academy.
- A serious incident relating to maternity care was raised. A woman with diabetes experienced a fetal demise at term and delivered the baby after being sent home, despite her wanting to stay in hospital. It was acknowledged that lessons could be learnt and learning includes identifying alternative care if the Bereavement Suite is occupied. We noted the appointment of a Diabetes Specialist Midwife and asked for an update at the next Academy.

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- The Academy heard about actions following the conviction of the neonatal nurse Lucy Letby. A public statement has been made and letters sent to parents whose babies are currently in neonatal care, or whose babies have died there offering reassurance and support. Affected staff and parents have been offered psychological support. No requests for information have yet been received from NHSE.
- The Academy Chair asked for an update on the ICB's tender process for technology to translate medicine labels and patient information. We were informed that this was ongoing to ensure appropriate coverage of the database and to ensure there would be no duplication of effort for staff. It was noted that 'we are sending some people home with medicines they do not know how to use' and the need for further discussion outside the Academy was identified. The Chair was keen to ensure that we learn from other NHS Trusts that have successfully implemented this product for the benefit of their patients. There is a need to address the challenges identified, which solution the Trust decides to use, and we must ensure that the technical requirements for medicine-related products are applied consistently to all products used at BTHFT. The Academy will receive an update at a future meeting.

Assure:

- We were assured that the Trust has processes in place to identify, investigate, manage and learn from safety events and serious incidents. We noted some improvements in relation to the category 3 pressure ulcers metric, and readmission rates reducing as length of stay has increased in line with regional average. It was identified that in future SI reports the Academy would prefer to see the inclusion of some additional narrative to explain the reason for the delay, where investigations are overdue.
- The Academy considered the high-level operational risks and was assured that these are being recognised, recorded, and action taken within appropriate timescales or explanation of changes to these timescales reported. The new report providing an oversight of changes to target mitigation dates was noted and welcomed.
- The Board Assurance Framework was discussed, and the Academy was assured that the identified strategic risks were receiving continued focus. The most significant risk is being unable to recruit to vacancies. It was noted that a higher number of newly qualified midwives, nurses and HCAs will be starting this Autumn. Measures to mitigate clinical staff attrition were highlighted. A reduction in the risk score for provision of training and learning experience was welcomed. This is due to improved GMC training survey results compared to last year, including plastic surgery and obstetrics and gynaecology, both of which had negative outlier areas last year.
- The Academy was assured of open and transparent oversight and scrutiny of Maternity and Neonatal services and that learning from incidents is appropriate. We acknowledged that 1:1 care in labour fell below the 90% target in June due to staffing

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levels. It was recognised that while there were no associated safety incidents, patient experience will have been affected and improvement is needed.

- The Academy were assured of progress against plans in the Digital Report. Some planned EPR record work has been paused ahead of Cerner implementation. A contractor will be employed to complete the ReSPECT work. The Academy asked for a record of backlogs to be provided. There was a discussion of the new Omnicell automated dispensing cabinets. Early 'teething problems' on some wards were noted but were assured staff now appeared happy with them.

Report completed by:

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Academy Co-Chair and Non-Executive Director
25 August 2023