Meeting Title	Board of Directors		
Date	18 January 2024	Agenda item	Bo.1.24.8

Committee/Academy Escalation and Assurance Report (AAA)

Report from the: Quality and Patient Safety Academy/Committee

Date of meeting: 13 December 2024

Key escalation and discussion points from the meeting

Alert:

Items reported under 'matters arising':

1. **Forthcoming Junior Doctor Industrial Action** - The dates have been confirmed for action to take place from 20 to 22 December inclusive. The industrial action is expected to have a significant impact on elective surgery with 600 of the 3,000 planned out-patient appointments being cancelled. Planning is again underway and ongoing as with previous industrial action.
2. **A&E and Hospital Flow** - Activity remains high within the A&E department and across the Trust with pressure on flow and beds. The situation remains difficult and challenging particularly with the forthcoming industrial action.

Advise:

1. Quality Oversight and Assurance Profile

In relation to the CQC report on caring for adults with a learning disability and health inequalities it was noted that all appropriate learning is fed through to the additional needs team and the vulnerabilities group which reports to the safeguarding group and to the Integrated Safeguarding Committee. Assurance provided.

2. CLIP (Complaints, Litigation, Incidents and Patient Experience) Report Q1&2

- 231 complaints received with the majority from the AED (against 70,000 attendances)
- Patient Advice and Liaison Service (PALS) received over 1,000 concerns – many cases resolved with first contact. No PALS issues remain open.
- 33 new claims received in Quarter 1 and 41 new claims received in Quarter 2 - a slight increase compared to the same period last year (19 have been closed with involvement of NHS Resolution).
- 123 inquests remain open with long delays experienced for listing: being monitored by Chief Medical Officer and the Medical Examiner's Office. During this period 44 new requests have been received and seven inquests held. The Academy noted that any learning following an inquest is circulated and shared with the relevant teams.
- Over 25,914 Patient Safety Incidents have been reported in total with falls, pressure ulcers and blood transfusion forming the three highest reported categories.
- During Q1 and 2 a total of 12 SIs have been reported.
- 31 RIDDOR reportable incidents were received – this is more than the number received for the whole of last year and the non-clinical risk team are scrutinising this information and data to seek to understand the reasons. This will be reported to the Academy at the end of February 2024.

This huge report triangulates data from many different areas. It was agreed that it would be improved by the addition of more analysis and insight. The Academy is keen to see this. This should be facilitated by the move to PSIRF and the transition from Datix to InPhase. The Academy also supported the addition of a metric to the Quality dashboard for the next year whilst the InPhase system is embedded, and staff become more familiar with the use of PSIRF.

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3. Electronic Patient Record (EPR) Programme update

The Academy received a high-level overview of the discussed and noted key EPR activity to date alongside the key deliverables planned for 2024/25. Of note were the items forming part of the EPR Programme deep dive – which covered: ReSPECT, Sepsis, HIV Services, Renal, SDEC, Discharge MPage and, Mobility. Some of these areas were at different levels of development or maturity. Two sessions had been held recently with clinical colleagues who are assisting with several of the programmes. The Academy was keen for this area of work to progress at pace and to continue with the involvement of the clinical colleagues.

Assure:

1. QPSA Dashboard

Two main points identified: (1) Summary Hospital-level Mortality Indicator (SHMI) which is higher than expected. The previously reported coding issues are being addressed and confidence that this is a statistical blip rather than a real deterioration in the position. A report will be presented to the System Quality Committee to provide further clarity. (2) Medical Examiner's (ME) Office. There is 100% scrutiny of all deaths in the Trust to provide assurance on the quality of care provided. This further supports the conclusion drawn on the SHMI position. C.Difficile, MRSA and Ecoli - there were '0' cases of C.Difficile and MRSA and approximately 6 cases of Ecoli reported for this month. In relation to Pressure Ulcers the position remains steady and within the usual limits. There has also been a steady improvement in 'Falls with Harm' demonstrating a welcome improving picture resulting from the related work undertaken during the year.

2. Maternity

- The LMNS Assurance visit was undertaken in November and the full report from the West Yorkshire & Harrogate Local Maternity & Neonatal System was shared with the Academy.
- A monthly stillbirth position of 2 was reported and the Academy was provided with a description of the incidents and any immediate actions/lessons learned.
- There are 8 ongoing maternity SIs/Level 1 investigations, 6 Maternity and Neonatal Safety Investigations (MNSI) and 2 Trust level.
- There was 1 reportable Serious Incidents (SI) declared in November.
- There were 10 occasions in November where the unit was assessed as needing to divert women to other organisations. In my previous chair report (November 2023), this is escalated to the Board. The Academy noted increased pressures in November, including the back log of inductions, and heard from the Director of Midwifery and the Chief Nurse on the steps taken to address and manage this situation. Assurance given.
- Following the November PROMPT training, the service can demonstrate full compliance with Safety Action 8 of the Maternity Incentive Scheme (90% of all staff groups within timeframe).

The Academy approved the three-year training plan, which forms part of the 'Core Competency Framework Version 2. Concerns were raised regarding the delivery of the plan over the next year as such a level of staff training may compromise safe staffing levels in the unit. Trusts may challenge the MIS for a review of the standard on this basis. The recommendation to Board will be however that the plan is approved as it is recognised that core training will improve safety.

3. SI report

- Bradford District and Craven Health and Care Partnership have approved the Trust's transition to the Patient Safety Incident Response Framework (PSIRF) from 1st December 2023, following the approval of the Trust's Patient Safety Incident Response Policy and Plan by the Trust Board of Directors.

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- The last declaration of a SI under NHS England's Serious Incident Framework was declared on the 28/11/2023 therefore the trajectory for investigation to be fully completed and submitted under these criteria is 28/2/2023.
- Test reporting of patient safety incidents to the NHS England Learning from Patient Safety Events (LFPSE) platform is continuing through the Trust's Datix test environment. Live reporting will commence when the Trust transitions from Datix to InPhase in January 2024.
- Between December 2022 and November 2023, the reporting of serious incidents (SIs) by the Trust has remained within normal cause variation except for January 2023.
- Our organisation continues to meet the Duty of Candour requirements and no breaches have occurred since August 2016.
- Academy has noted that of the 8 Trust led serious incident investigations extensions are in place for 3 investigations and heard that work is ongoing to reduce the number of extension requests made to ensure we can close outstanding SI investigations as quickly as possible to extract any further learning and progress our transition to PSIRF.
- Academy also noted that a new assurance report would be developed reflect the new investigation arrangements under the Patient Safety Incident Response Framework.

4. Safeguarding Adults and Safeguarding Children – Six monthly update

Two comprehensive mid-year reports from the Safeguarding leads for Adults and for Children.

- The two teams are closely linked with some crossover agendas such as MCA/Deprivation of Liberty Safeguards (DoLS) and work closely together to achieve safety outcomes.
- It was good to hear about the development of the Navigator role under 'Safeguarding Adults' and the positive feedback this was eliciting from carers and other professionals. It was hoped this may become a permanent role.
- The Mental Capacity Act assessment template is now live in EPR as of 12 December 2023 and the new 'best interest' template is also live in EPR - this will allow regular audits to review the quality of the information and is a strong, powerful, and legally robust tool.
- The Children's safeguarding training has been reviewed by the place and all training delivered from 2024 will be multi-disciplinary. The teams are seeing an increasing complexity in safeguarding issues including an increase in domestic abuse.
- Reference was made to the concerns raised in June 2023 regarding the inability of Cerner to link with SystmOne. This remains a longstanding issue and an update has been requested from the Chief Digital and Information Officer on particularly on progress to date regarding electronic records in relation to safeguarding children.

The Academy requested that the Childrens safeguarding lead share the response to their annual report from the ICB to provide additional assurance in this area.

5. Board Assurance Framework

There has been no change since the last BAF review, and no change made to any of the risk scores. The Academy has concluded that the risks are being appropriately managed and confirm that there are no matters to escalate to the Board of Directors' January 2024 meeting.

Report completed by:

Professor Louise Bryant, Academy Chair and Non-Executive Director and
Jacqui Maurice, Head of Corporate Governance