Bradford Teaching Hospitals
NHS Foundation Trust

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: 29 November 2023

Key escalation and discussion points from the meeting

Alert:

Maternity and Neonatal Services Update

The board is asked to note that during November there was a significant backlog of women awaiting planned inductions. The reasons for the development of this backlog were multi-factorial and the position was escalated by the Chief Nurse to the ICB Chief Nurse who in turn escalated to the NE&WY Regional Midwife. During this period one case of harm occurred leading to the unfortunate death of a baby to a woman waiting for induction for a clinical reason.

Details discussed at Academy:

- The maternity unit has a significant backlog of inductions which has contributed to a recent case of harm, in which an intra-uterine death occurred.
- The unit has experienced challenges as there have been unintended consequences on the back of 'point of care testing' related to the Trusts participation in a research project which involves testing for Streptococcus B (very dangerous for babies but not for mothers). This has though led to an increased 'length of stay' for mothers (and their babies) who would otherwise be fit to be released.
- There have also been changes to NICE guidance - around the timing of the offer of induction of labour - which have also had an unintended consequence on the scheduling of inductions.
- Staffing was also presenting challenges.
- The challenges being faced by the ward were escalated to the ICB Chief Nurse Beverley Geary, who in turn escalated to Tracey Cooper, Chief Midwife for the North East and Yorkshire, NHS England.
- Regularity of meetings increased following the case of harm. Actions put in place included additional on-call senior midwives to help get through the volume of inductions.
- Mutual aid has also been sought (and given) from neighbouring trusts.

Team has seen real harm as well as an impact on patient experience. Situation being monitored. Difficult questions with regard to ensuring capacity for Bradford babies over babies coming from other areas.

Advise:

Increased attendance in A&E – reported under matters arising

Over the last two weeks there have been increased attendances at A&E with quite a few days with more than 400 attendances daily. This has led to increased pressures on the

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hospital site and concerted efforts are being made to discharge patients as long as it is safe to do so.

SI Report

- Test reporting of patient safety incidents to the new NHSEI Learning from Patient Safety Events platform, which is replacing the outdated National Reporting and Learning System (NRLS) commenced in September 2023. Live reporting will commence when the Trust transitions from Datix to InPhase.
- One SI was declared during October.
- There are 11 ongoing SIs at the time of the report, 4 are being investigated by the Maternity and Newborn Safety Investigations (MNSI) programme, 3 within the 60 day deadline and 1 HSIB within the 160 day deadline.
- 7 investigations are underway, 3 of which are HSIB investigations, with extensions in place.
- One SI has concluded – lessons learned shared and discussed with the Academy.
- Academy discussed the impact of PSIRF (Patient Safety Incident Response framework) on the nominal 60-day time limit for completion of SIs currently in place. Academy advised of amendments to the terms of reference for key sub-groups (Safety Event Group, Quality of Care Panel and Patient Safety Groups) to reflect the process for tracking actions. Assurance will be provided to the Academy via the Complaints, Litigation, Incident & PALS (CLIP) report to ensure that assurance and learning is embedded, and actions completed.

Health Inequalities

The Academy discussed ways of improving information presented moving forward which would benefit from the addition of tangible examples of the work undertaken in this area along with the outcomes and actions. Key area discussed was how to engage staff with this area, particularly given that staff are patients too and the majority are part of our local populations and as such have lived experience that can support improvements in patient experience and, can proactively support tackling health inequalities.

Equality Delivery System 2022

Key to note the work underway in relation to the NHS Equality Delivery System 2022 (EDS22) framework.

The Academy discussed the importance of acknowledging that the majority of our staff are part of the local community and as such are also our patients and service users. The Trust should be taking on board the valuable insights offered by staff regarding patient experience – this connection should be made more apparent so that staff also feel empowered to engage with improvements and help to address health inequalities.

Assure:

High Level Risks

- There is one risk past its target date – Risk ID 3810 – pressures on haematology services.
- The risk has subsequently been updated due to a lot of work with the service. The target date has been extended to September 2024.

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- There is one new risk – Risk ID 3896 – histopathology delays resulting from samples from gynaecological services.
- One risk has been closed – Risk ID 3800 - Cost of gas and power.
- There are two risks which have reduced in score:
  - Risk ID 3732 – nursing and midwifery staffing levels.
  - Risk ID 3881 – pharmacy vacancies.
- There is one risk past its review date – Risk ID 3696 – Pharmacy aseptic unit. The review date is now amended to 31 December 2023.

IPC update

The numbers of MSSA bacteraemia infections in the community are rising which is reflected in the rise in patients being admitted who are testing positive. A challenging situation however the IPC team has put measures in place to address the situation.

Report completed by:

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