Meeting Title	Board of Directors		
Date	16 November 2023	Agenda item	Bo.11.23.14

Committee/Academy Escalation and Assurance Report (AAA)

Report from the: Quality and Patient Safety Academy/Committee

Date of meeting: 1st November 2023

Key escalation and discussion points from the meeting

Alert:

Neonatal SIs Review

The October 2023 QPSA was held on 1st November 2023. Since the last QPSA meeting in September, there have been significant change in Trust leadership, adverse media coverage, NHSE and CQC interest in to concerns raised by the former Chair.

It was prudent to devote extended time to explore the most serious issues raised that are pertinent to the QPSA. These were the neonatal incidents from April 2021. In seeking assurance into these cases a wider look at neonatal events during the period from April 2021 to March 2022, when the SI reports were formally approved, were reviewed from a quality, reporting and governance perspectives.

The extended session had an open invitation to non QPSA Board members and governors. Additional assurance can be taken from this session with some key lessons identified. NHSE have a separate Rapid Quality Review that is ongoing.

Learning from Deaths and SHMI

The issue of BTHFT being an outlier on SHMI mortality data was discussed again. It was identified that the likely reason for the poor SHMI comparator is due to a poor depth of coding. BTHFT apparently has the second worst depth of coding in the UK. It is unclear how and why this happened but action needs to be taken to address. It is expected that as depth of coding improves, this will also improve the SHMI mortality data. There is no concern around the crude mortality data, therefore this is being treated as a data quality issue. Improvements in this area should be monitored by the QPSA and Board.

Advise

There are a number of areas where the Board needs to be aware of progress.

Unexpected children's deaths

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The QPSA was informed of a spike in unexpected children deaths in the period 28/09/23 – 17/10/23. A paper was brought for information only. There were 6 deaths. Details were provided to the QPSA. Investigations and clinical reviews will continue. There was an agreed action that criteria should be established on when unexplained death numbers or trends should be brought to the QPSA, but not every death should be routinely brought to the QPSA.

Assure:

CQC National in patient survey results were reviewed by the QPSA. Bradford Teaching Hospitals NHS Foundation scored as being better than most Trusts for 1 question and worse than most Trusts for 16 questions. There are 28 questions that are about the same as other Trusts. This was a small sample, but does identify areas for continued focus.

The survey is conducted in English and as previous years does not reflect the diversity of our population.

PSIRF

The QPSA reviewed the PSIRF response plan and policy documentation. The QPSA welcomes the PSIRF approach that the Trust will switch to in December 23. There was a Board development day on PSIRF in October, but due to the extra demands on Board colleagues during a turbulent time, not all could attend. The materials from the training will be circulated to all Board members and a repeat of the session will be planned.

Quality Oversight and SIs

13 safety events were reported externally. As of end of September 2023, there were 11 ongoing Sis, of which 4 have extensions in place. The QPSA queried the length of time that some Sis are taking and sought assurance that the reasons for delays are clearly stated. The number of extensions sought for some SIs was discussed. Assurance was given that this is monitored and a change has been made so that all extensions are for a standard 4 week period, so that it is simpler to see the number and lengths of extensions granted. There was a discussion on how timelines might be managed for PSIRF. It was confirmed that PSIRF reviews would have a 6 month timeline, but this can also be determined at the outset of each review. The QPSA discussed the assurance metrics that the QPSA/Board may require from PSIRF.

High level risks

1 new risk has been added to the High Level Risk Register;

3824 - Emergency Department Medical Staff Coverage – weekend and evenings

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ETM also agreed to add a risk to the HLRR relating to the potential reputational damage and impact following the resignation of the Chair. This is reported to Closed Board.

Two risks have been closed: 3598, 3630.

1 risks is beyond its review date:

3808 – Risk of industrial action, review date 15/09/23

1 risk beyond its target mitigation date:

3800 – Increase in the cost of gas and power, target date 01/08/2023

Report completed by:

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November 2023