Bradford Teaching Hospitals NHS Foundation Trust

Board of Directors: 8.3.18
Agenda Item: Bo.3.18.24

Confirmed Quality Committee Minutes
December 2017 & 31 January 2018

Presented by:	Laura Stroud, Chair	**Author:**	Fiona Ritchie, Trust Secretary
Previously considered by:	Quality & Safety Committee		

Key points	**Purpose:**
Quality Committee minutes 20 December 2017 & January 2018	To note

Executive Summary
Quality Committee minutes 20 December 2017 & January 2018

Financial implications:
No

Regulatory relevance:

Monitor:	

Equality Impact / Implications:	Choose an item.
	Choose an item.
	Choose an item.
	Is there likely to be any impact on any of the protected characteristics? (Age, Disability, Gender, Gender Reassignment, Pregnancy and Maternity, Race, Religion or Belief, Sexual Orientation, Health Inequalities, Human Rights) Yes ☐ No ☒ If yes, what is the mitigation against this?

Other:	

Strategic Objective: *Reference to Strategic Objective(s) this paper relates to*	To provide outstanding care for patients
	Choose an item.
	Choose an item.
	Choose an item.
	Choose an item.

Bradford Teaching Hospitals NHS Foundation Trust

QUALITY MEETING MINUTES, ACTIONS & DECISIONS

Date:	Wednesday 20 December 2017	**Time:**	14:00-16:00
Venue:	Conference Room, Field House, Bradford Royal Infirmary	**Chair:**	Laura Stroud, Non-Executive Director
Present:	**Non-Executive Directors:** - Professor Laura Stroud, Non-Executive Director (LS) - Mr Amjad Pervez, Non-Executive Director (AP) **Executive Directors:** - Ms Donna Thompson, Director of Governance and Operations (DT) - Ms Karen Dawber, Chief Nurse (KD) - Dr Bryan Gill, Medical Director (BG) - Ms Cindy Fedell, Director of Informatics (CF)		
In Attendance:	- Ms Fiona Ritchie, Trust Secretary (FR) - Ms Jacqui Maurice, Head of Corporate Governance (Minutes) - Dr Sue King, Clinical Lead Urgent Care\AED Consultant (SK) - agenda item Q.12.17.5 - Mr Brad Wilson, Consultant A&E (BW) - agenda item Q.12.17.5 - Mr Simon Kirk, Directorate Manager Emergency Care (Ski) - agenda item Q.12.17.5 - Ms Jo Stedman, Matron AED (JS) - agenda item Q.12.17.5		
Observers	- Mr Barrie Senior, Non-Executive Director - Mr Steven Picken, Delloite LLP		

No.	Agenda Item	Action
Q.12.17.1	**Apologies for Absence**	
	- Mr Mohammed Iqbal, Non-Executive Director (MI) - Ms Selina Ullah, Non-Executive Director (SU)	
Q.12.17.2	**Declaration of Interests**	
	There were no declarations of interest.	
Q.12.17.3	**Minutes and Actions of the Quality Committee meeting held on 29 November 2017**	
	The minutes were accepted as a correct record.	
Q.12.17.4	**Matters Arising**	
	The Committee noted that the following actions had been concluded. 1. Q.7.17.5 - Serious Incident (SI)/Never Events Report. A report on the Cancer MDT Process Assurance is presented at agenda item Q.12.17.10. Action concluded. 2. Q.10.17.7/8 Information Governance Report - Senior Information Risk Owner 2017/18 Quarter 2 Update. An update on the action plan is presented at agenda item Q.12.17.7. Action concluded. 3. Q.10.17.17 Responding and Improving: Maternity Improvement Action Plan. The Action Plan is included at agenda item Q.12.17.13. Action concluded. 4. Q.8.17.15 – Serious Incident (SI)/Never Event Report Item included in the December SI report. Action concluded.	

No.	Agenda Item	Action
	5. Q.11.17.21 Safeguarding Adults Mid-Year update 2017/18 Item on the December 2017 Committee agenda. Action concluded. 6. Q.11.17.26 Matters to Escalate to the Corporate Risk Register Item escalated to the IGRC. Action concluded. *Post-meeting note:* 7. *Q.11.17.24 Board Assurance Framework – SR4. An Urgent Care Recovery Plan will be added to the agenda for the 31 January 2018 Quality Committee.* Action concluded.	
Q.12.17.5	**Accident and Emergency (A&E) Deep Dive**	
	SK, BW, SKi and JH delivered a comprehensive presentation covering developments within A&E. The Committee discussed in detail: - Capacity and demand modelling. - The relationship with the Urgent Care Board and the progress made during the previous year. - The challenges that continue to be experienced with Primary Care and the need to advise patients of the alternatives to A&E. - The positive actions and benefits to patient care resulting from the work being undertaken with regard to the Mental Health CQUIN. - The support provided by the Organisational Development Team leading to improvements in the culture of the A&E team and subsequently, improvements in the quality of care provided. - The benefits brought by improvements in staff training and development. - Benefits from Capital programme investments and investments in staffing. - The continued work required to achieve the A&E targets. - Ensuring compliance with policies and procedures. - Improvements in the management of staff to support effective and efficient staff communication at handovers. KD referred to the 'super trolleys' which a number of other A&E teams across the NHS had access to. She agreed to support a bid by the A&E team to the Charitable Funds Committee for the acquisition of 'super trolleys' to enhance what is currently provided within the department. LS thanked SK, BW, SKi and JH for the presentation. She formally commended the A&E department for the evidence provided of strong and visible leadership and, the assurance that actions had been implemented and embedded.	Chief Nurse
Q.12.17.6	**Quality Committee Dashboard**	
	LS stated that, as the Committee was aware, this was a new iteration of the dashboard. The Committee noted that a number of items within the dashboard were scheduled for discussion later in the meeting. The Committee noted the following: - The mortality data was a high level indicator comprised of two separate measures. BG stated that both measures consistently showed performance that was better than expected. - More immediate information regarding the daily and weekly positions for Venous Thromboembolism (VTE) Assessment was now available from the EPR and as such was supporting more immediate actions taken for improvement in those clinical areas with low rates. - With regard to the data presented on the Category 3 Pressure Ulcers; the correct figure for October 2017 should be 8 and not 11 as presented on the	

No.	Agenda Item	Action
	dashboard. - The dashboard has reflected the Care Quality Commission (CQC) metrics and actions from previous CQC inspections. The Committee agreed that it would be useful for the dashboard to be developed further to record: - The key risks, issues, and patient outcomes from 'deep dive' presentations received by the Committee to enable a review of progress against expected outcomes over time. - The factors key to Bradford and its development as a young entrepreneurial city that the Foundation Trust might be able to capitalise on or should take account of. CF stated that she would consider with her team how that information should be included. The Committee noted the report.	Director of Informatics
Q.12.17.7	**Information Governance Report**	
	CF informed the Committee that no level 2 high risk reportable information governance breaches have occurred year to date. The Committee also noted that: - Information Governance training compliance has improved and is at 88%. This is below the 95% requirement for March 2018 however plans are in place to address the gap. - Planning is underway to ensure the Foundation Trust is compliant with the new General Data Protection Regulation (GDPR) from May 2018. - The recommendations arising from the Information Commissioner's Office (ICO) best practice visit in November 2016 have been implemented. The update to the ICO is due at the end of December 2017 at which point the Foundation Trust would be advised if the ICO would be undertaking a follow up audit in January 2018. The Committee noted the report.	
Q.12.17.8	**Strategic Staffing Review**	
	KD advised that the Strategic Staffing Review would now be presented annually to the Board of Directors. She provided a detailed presentation on the work and engagement with the nursing establishment that has informed the Strategic Staffing Review. The discussion focussed on the: - Individual sessions held with each of the ward managers and matrons - Consideration given to the acuity of patients. - Ward 360 degree reviews - Recruitment and Retention of nursing staff including the potential for the development of new roles within available budgets AP stated that this was an excellent piece of work and enquired about individual progression opportunities being developed for staff. KD stated that an internal conference had been held recently at the Foundation Trust to launch the Health Professionals Framework. Two key areas of focus at the conference covered the development of junior staff and; the support package developed for Black, Asian and Minority Ethnic (BAME) Staff to support progression into band 6 and 7 roles. DT added that the process undertaken for the Staffing Review fits well with the Values work underway at the Foundation Trust however it was also important to ensure that feedback was provided to staff on the actions undertaken and the outcomes in relation to the review. The Committee noted	

No.	Agenda Item	Action
	and gained assurance from the report.	
Q.12.17.9	**Serious Incident Report**	
	BG asked the Committee to note that five Serious Incidents had been declared in the last month; three of which were pressure ulcers. The other two concerned: - A patient who had surgery to remove a metastatic renal tumour under general anaesthetic and arrested immediately post operatively. - A paediatric safeguarding concern relating to a child who attended A&E. The appropriate safeguarding checks were not undertaken which would have identified that the child was known to be on a child protection plan. BG further advised that three investigations have been completed and their reports submitted to the Clinical Commissioning Group (CCG) for approval and closure on the Strategic Information System. These related to: - The failure to haemodialysis a Hepatitis B virus (HBV) positive patient on a designated individual machine. - The failure of the Temple Bank generator to provide appropriate backup power during a mains power cut. - The death of a cancer patient who developed sepsis. The Committee discussed in detail the outcomes and actions resulting from the Serious Incidents and how assurance had been provided with regard to ensuring that actions were monitored and learning disseminated. The Committee noted and gained assurance from the report.	
Q.12.17.10	**Cancer MDT Process Assurance**	
	BG asked the Committee to note the content of the comprehensive report which provided a good overview of the work undertaken to address the issues previously experienced. The Committee noted the positive outcomes from the actions implemented. BG stated that all the actions were linked to the Cancer Improvement Programme and further updates would be provided in relation to future reporting with regard to the Cancer Board. The Committee noted and gained assurance from the report.	
Q.12.17.11	**Combined Learning Report - Q2 2017-18**	
	BG asked the Committee to note the report which summarised how the Foundation Trust used incidents to share key messages. He advised that discussions regularly took place on the range of methods to be used for communicating learning across the organisation – a good example of which was the Learning Hub that was referred to in the A&E presentation to the Committee. A detailed discussion followed which focussed on the following key areas: - Quality Summits and their role as support systems in facilitating transparent conversations. - Learning from complaints and ensuring that staff address issues to help drive improvements. - The role of the Committee in challenging itself to seek assurance with regard to the effectiveness of the measures taken to support improvements. - The focus to be applied to the Board Assurance Framework (BAF) with regard to reviewing the actions and outcomes to support improvements in Quality. The Committee noted and gained assurance from the report.	

No.	Agenda Item	Action
Q.12.17.12	**Children and Young People's Board Report**	
	BG advised that the report provided a six month summary of the work that had taken place. He asked the Committee to note that the Ambulatory Care work had now been launched and, a Joint Inspection in relation to Safeguarding had taken place. BG drew attention to the plans for the delivery of an Autism Service where it had become evident that a system-wide approach to the delivery of an effective service was required. The Committee noted the report.	
Q.12.17.13	**Maternity Improvement Programme Action Plan v3**	
	KD reminded the Committee of the previous reports received with regard to the Maternity Improvement Programme which had been developed and implemented following the initial Maternity Summit held in December 2016. KD stated that a second Maternity Summit was held on 13 November 2017. The summit, chaired by Professor Laura Stroud, had participation from a range of key Foundation Trust staff including the Maternity Team and Chief Nurse. The summit was attended by representatives from the CCG, General Practitioners, NHS Improvement and the CQC and, with openness and full transparency; covering in detail the transformations that had taken place to improve the Service. KD advised there was full agreement at the Summit that excellent progress had been made and that concerns had been addressed. A meeting would take place in six months' time to assess the position. KD would feedback to the Committee the outcome of this meeting. AP referred to the actions to address the needs of the Black, Asian and Minority Ethnic (BAME) population. KD described the actions underway with regard to communications and the focus being placed on 'hard to reach groups'. AP suggested linking with the Well North initiative and its connections with schools which might provide further opportunities to support effective communications. The Committee noted the outcome from the Maternity Summit and approved the recommendation that "the Maternity Improvement Programme summit process is de-escalated and that regular monitoring would now continue via the Quality Committee".	Chief Nurse
Q.12.17.14	**Prevent Training Update**	
	KD reminded the Committee of the requirement for 85% of eligible staff to have completed the Prevent training. She advised that: - The staff trainers and the electronic resource to support the training were now in place. - The Safeguarding Team had mapped a trajectory to achieve a compliance rate of 86% by the end of March 2018. - Staff required to undertake the Level 3 Safeguarding Training were also required to undertake the Prevent training and as such their training had been linked through the system. - Links would also be made with Performance Reviews which will be monitored on a monthly basis with the Divisions. - The Prevent training would be added to the Training Tracker. - Future updates would be provided on training and compliance to the Committee.	

No.	Agenda Item	Action
	KD assured the Committee that the sensitivities surrounding the delivery of the training had been thoroughly considered. She referred to previous discussions at the Board of Directors concerning the need for care to be taken on how the training is delivered. KD assured the Committee that the right people with the right skills were in place. The Committee noted the report and the trajectory.	
Q.12.17.15	**Central Alerting System (CAS) Report**	
	DT advised that the Central Alerting System (CAS) was a National System that issued patient safety alerts, important public health messages and other safety critical information and guidance to the NHS. Trusts were then required to have processes in place to ensure that it acted on the recommendations and the advice provided. DT advised that the report provided a list of those alerts received during Quarter 2 along with the associated activity undertaken by the Foundation Trust. DT asked the Committee to note that there were no outstanding concerns. The Committee noted and gained assurance from the report.	
Q.12.17.16	**CQC Fundamental Standards: Inspections, Compliance and Assurance**	
	DT advised that the paper provided a position statement with regard to the Foundation Trust's compliance actions following the inspections held in October 2014 and January 2016. DT asked the Committee to note the assurance provided as part of the Internal Audit review processes with regard to two of the compliance requirements. She added that discussions have also been held with the CQC which have confirmed their satisfaction with the assurance metrics in place. The Committee noted the areas that were outstanding and, the actions to be undertaken in relation to them. DT advised that the CQC Well-Led visit has been confirmed for the 6 to 8 February 2018 and it was expected that the Foundation Trust will have an unannounced inspection prior to then. The Committee noted and gained assurance from the report.	
Q.12.17.17	**Annual Governance review of the Terms of Reference for Sub-committees of the Quality Committee**	
	DT presented the outcomes of the review which had been undertaken in response to the Committee's concerns about the levels of attendance at a number of the sub-committees. Following discussion DT stated that her team would contact the Chairs of the sub-committees and ask them to consider if their membership is appropriate and, if they are able to deliver on their Terms of Reference.	Director of Governance and Corporate Affairs*
Q.12.17.18	**Board Assurance Framework**	
	The Committee noted its responsibility for two strategic risks: - SR1: To provide outstanding care for our patients – for which the Executive Leads are the Chief Nurse and the Medical Director. - SR4: To be a continually learning organisation – for which the Executive Lead is the Medical Director. LS asked the Committee to note that the discussions held during this meeting have provided insights across these two domains and the actions underway at	

No.	Agenda Item	Action
	the Foundation Trust. DT referred to the previous agenda item, Q.12.17.17, and asked if the concerns raised regarding the sub-committees should be reflected within the BAF. It was agreed that DT, KD and BG should meet with the Assistant Director of Governance and Risk to consider this and report back to the Committee. The Committee noted and gained assurance from the discussions held and the report.	Director of Governance and Corporate Affairs*
Q.12.17.19	**Any Other Business**	
	There were no items to be discussed.	
Q.12.17.20	**Matters to Escalate to the Corporate Risk Register**	
	There were no matters to escalate to the Corporate Risk Register.	
Q.12.17.21	**Matters to Escalate to the Board of Directors**	
	The key matters to escalate to the Board of Directors were: - A &E Quality Summit Follow Up - Serious Incidents - Maternity Improvement Programme - CQC Compliance - Review of Sub Committees reporting into the Quality Committee	
Q.12.17.22	**Items for Corporate Communications**	
	There were no items for Corporate Communications.	
Q.12.17.23	**Date and time of next meeting**	
	Wednesday 31 January 2018, 2pm to 4pm, Conference Room, Field House, Bradford Royal Infirmary.	

Bradford Teaching Hospitals NHS Foundation Trust

BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST
ACTIONS FROM QUALITY COMMITTEE – 20 December 2017

Date of Meeting	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
29.11.17	Q.11.17.24	**Board Assurance Framework** – SR4 – An overall delivery plan has been developed for the FT and DT agreed to share this with the Committee.	Acting Chief Operating Officer*	31/01/18	20/12/17 post-meeting note: An Urgent Care Recovery Plan will be added to the Quality Committee agenda for 31 January 2018. Item added to the January 2018 Committee agenda
25.10.17	Q.10.17.12	**Venous Thrombo-embolism – Assessment and Prevention Action Plan** – A detailed report will be brought back to the Committee providing assurance in relation to the effectiveness of the action plan at a time and in a format agreed by the Committee.	Medical Director	31/01/18	Item added to the January 2018 Committee agenda
20.12.17	Q.12.17.17	**Annual Governance review of the Terms of Reference for Sub-committees of the Quality Committee:** DT stated that her team would contact the Chairs of the sub-committees and ask them to consider if their membership is appropriate and if they are able to deliver on their Terms of Reference.	Director of Governance and Corporate Affairs*	28/02/18	
20.12.17	Q.12.17.18	**Board Assurance Framework**: DT referred to the previous agenda item regarding the sub-committees and asked if this should be reflected within the BAF. It was agreed that DT, KD and BG should meet with the Assistant Director of Governance and Risk to consider this and report back to the Committee.	Director of Governance and Corporate Affairs*	28/02/18	

Date of Meeting	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
20.12.17	Q.12.17.5	**A&E Deep Dive:** KD agreed to support a bid by the A&E team to the Charitable Funds for the acquisition of 'super trolleys' to enhance what is currently provided within the department.	Chief Nurse	28/03/18	
20.12.17	Q.12.17.6	**Quality Committee Dashboard**: CF to consider with her team how to develop the dashboard to record: - The key risks, issues, and patient outcomes from 'deep dive' presentations received by the Committee to enable a review of progress against expected outcomes over time. - The factors key to Bradford and its development as a young entrepreneurial city that the Foundation Trust might be able to capitalise on or should take account of.	Director of Informatics	28/03/18	
20.12.17	Q.12.17.13	**Maternity Improvement Programme Action Plan:** KD advised there was full agreement that excellent progress had been made and that concerns had been addressed. A meeting would take place in six months to assess the position. KD to feed back to the Committee the outcome of the meeting	Chief Nurse	27/06/18	

*****TITLES ALTERED TO REFLECT DIRECTOR PORTFOLIO CHANGES 8/1/2018

Bradford Teaching Hospitals NHS Foundation Trust

QUALITY COMMITTEE
MINUTES, ACTIONS & DECISIONS

Date:	Wednesday 31 January 2018	**Time:**	14:00-16:35
Venue:	Conference Room, Field House, Bradford Royal Infirmary	**Chair:**	Professor Laura Stroud Non-Executive Director
Present:	- Professor Laura Stroud, Non-Executive Director (LS) - Mr Amjad Pervez, Non-Executive Director (AP) - Dr Mohammed Iqbal, Non-Executive Director (MI) - Ms Selina Ullah, Non-Executive Director (SU) - Ms Donna Thompson, Director of Governance and Corporate Affairs (DT) - Ms Cindy Fedell, Director of Informatics (CF) - Ms Sally Scales, Deputy Chief Nurse (SS) - Dr LeeAnne Elliott, Deputy Medical Director (LAE)		
In Attendance:	- Ms Sandra Shannon, Acting Chief Operating Officer (SSh) – In attendance for agenda item Q.1.18.8 - Ms Tanya Claridge, Assistant Director of Governance and Risk (TC) – In attendance for agenda item Q.1.18.11 - Kay Rushforth (KR), Head of Nursing, Children's Services – In attendance for agenda item Q.1.18.18 - Dr Shaun Gorman (SG), Consultant Paediatrician – In attendance for agenda item Q.1.18.18 - Ms Fiona Ritchie, Trust Secretary (FR) - Ms Juliet Kitching, EA, Trust Headquarters (Minutes)		
Observer:	- Mr Barrie Senior, Non-Executive Director (BS) - Ms Sandra Shannon, Acting Chief Operating Officer (SSh)		

No.	Agenda Item	Action
Q.1.18.1	**Apologies for Absence** - Ms Karen Dawber, Chief Nurse (KD) represented by Ms Sally Scales, Deputy Chief Nurse - Dr Bryan Gill, Medical Director (BG), represented by Dr LeeAnne Elliott, Deputy Medical Director	
Q.1.18.2	**Declaration of Interests** There were no declarations of interest.	
Q.1.18.3	**Minutes and Actions of the Quality Committee meeting held on 20 December 2017** The minutes were accepted as a correct record.	
Q.1.18.4	**Matters Arising** The Committee noted that the following actions had been concluded. Q.11.17.24 – Board Assurance Framework. Q.10.17.12 – Venous Thrombo-embolism – Assessment and Prevention Action Plan.	

No.	Agenda Item	Action
Q.1.18.5	**Quality Committee Dashboard** LS presented the Quality Committee dashboard and discussion held with regards to the following issues. Hospital standardised mortality ratios and mortality ratios: The Committee noted the Foundation Trust (FT) is clearly performing better than other comparative Trusts showing a 'green' indicator on both sides. Harm: SS noted a focused programme is in place to reduce falls, using the quality improvement methodology, led by the Associate Chief Nurse for Quality Improvement, supported by the Medical Director's Office. Catheter and urinary tract infections: SS discussed the Infection, Prevention and Control plans to reduce infections and the opportunities available to use the Electronic Patient Record (EPR) to support audit work and improve data quality. SS noted previous data recording issues which had now been rectified. Pressure ulcers: SS noted the slight overall reduction since October and the continuing work undertaken as part of the collaboration, especially with Category 3 pressure ulcers. Work to reduce Category 2 pressure ulcers continues, however, the FT benchmarks well against Category 2. Both areas, however, remain a focus. Complaints: SS recognised the ongoing pressures particularly around the response times for complaints. The Parliamentary Health Service Ombudsman had visited in December 2017 as part of an informal training visit and expressed satisfaction with the quality of the responses and the vigorous process around checking. The policy now allows the investigator to agree with the complainant an extension to the default time of 30 days for complex complaints. There is facility to record this within Datix but staff are not always adjusting this accordingly, this is an area for improvement. AP questioned as to what proportion of complaints received include reference to the Accident and Emergency Department and other areas. SS noted that this information is included in the quarterly patient experience report. AP asked about whether work was undertaken to map out the patient timeline in outpatients. SS reported that this work is undertaken in the outpatient improvement work stream. Night-time transfers: SSh reported an increase of night-time transfers in December. Within that period the FT experienced significant winter pressures resulting in higher admissions later on in the day resulting in later transfers. This is a key area of focus to increase diagnostics earlier in the day and free up beds to enable earlier admissions. Although there is no significant seasonable difference in admissions from summer to winter this year, we have seen an increase in emergency admissions. Length of stay does increase during winter due to increased acuity, both of these impact on bed pressures and the Trust's ability to manage flow effectively. Transfer planning was discussed by SSh and the procedures around night-time transfers. The Committee noted that an update had been provided to the Finance and Performance Committee. If this continues to remain a risk a deep dive will be required.	

No.	Agenda Item	Action
	Readmission from electives: SSh discussed the recording of the data quality metrics in terms of the trends, particularly for readmission, and suggested if these continue to remain a risk a deep dive may be organised. Training compliance: LAE discussed high priority training compliance figures and the impact following EPR training. Figures were noted to be improving. Mitigation of Risks: DT noted this new indicator displaying a number of risks that were not adequately mitigated against. A Board session is being held next week on risk appetite. The report was noted by the Committee.	
Q.1.18.6 **Q.1.18.7**	**Information Governance (IG) Report** **Senior Information Risk Owner 2017/18 Quarter 3 Update** CF discussed the two reports and highlighted the key headlines. One Level 2 high risk reportable IG incident had been reported involving unauthorised access by a number of members of staff to one patient's record. The investigation has begun and will be reported back in a future IG report. Mandatory IG training compliance is at 87% as of 31 December 2017. Plans are in place to facilitate an improvement in the figure before year end. The Information Commissioner's Office best practice audit was undertaken a year ago for the purposes of learning. A limited assurance report was received at the time. The status and evidence on the action plan was submitted in December 2017. A response to this is awaited. CF noted the data quality indicators that are being managed operationally. Work is still to be undertaken around Information Asset Owners and the robustness of the Information Asset Register, which is a step-change improvement from previous years. General Data Protection Regulation (GDPR) preparedness is progressing and intensive work effort is being applied. Hempsons have been invited to provide an overview of GDPR to the Board of Directors. LS noted the best practice audit was raised at the Informal Council of Governors meeting. CF will be invited to their next meeting to discuss. SSh noted a review of productivity post-EPR is being done specialty-by-specialty, noting most areas have returned to pre-EPR levels of planned activity. Extra support for clinicians is being given where required to assist with the processes. With regards paper notes, CF noted that the Scanning Bureau has fallen behind in scanning and this is being remedied. A review of paper notes provided is planned for the 12-month mark. LS raised the issue of the change of a patient record for those individuals who have undergone gender reassignment. CF will check the process is aligned with national guidance. The Committee noted the papers.	Trust Secretary Director of Informatics
Q.1.18.8	**Urgent Care Recovery Plan** SSh noted the quality and safety elements have been added into the overarching Emergency Care Improvement Plan following the deep dive presentation at the December Committee meeting. The full plan had been	

No.	Agenda Item	Action
	attached for information only. The twelve objectives were noted and the key actions to be addressed will be focused on and evidence collated with the impact and benefits to patients being explored. SSh discussed in detail the Urgent and Emergency Care Programme Project Progress table on page 2 of the report. The three areas to provide the largest impact in terms of improvement will be the areas of focus. The report was noted by the Committee and it was agreed that Quarterly Reports would be presented to this Committee.	Acting Chief Operating Officer
Q.1.18.9	**Serious Incident (SI) Report** LAE noted four new SIs have been reported during December 2017, with one of these relating to a hospital acquired pressure ulcer which will be investigated via the Root Cause Analysis Panel. LAE outlined the remaining three cases: SI 2017/30191 - A patient who absconded from a ward on to a roof top. Immediate actions were put in place and the investigation is ongoing. SI 2017/30221 - A delayed diagnosis and treatment of a patient with oral cancer. The patient is now being managed appropriately. A complex investigation is underway. SI 2017/30313 - Over thirty thousand items of correspondence were not transferred successfully from the EPR system to Primary Care when the system went 'live'. An intermediary company is involved and an investigation is ongoing. A Task and Finish group has been set up and the FT is in contact with the Clinical Commissioning Groups (CCG) and General Practitioners. The information is now despatched in an agreed method and a review of documentation to ensure no harm has been caused by any delay in communication is underway. Two extensions for reports have been agreed by the CCG resulting in the delay to the commencement of investigations, the first regarding an allegation of sexual assault, which has been the subject of a Police investigation, and the second an intrauterine death which is undergoing external review. The Committee noted the report.	
Q.1.18.10	**Quarterly Risk Management Report – Quarter 3** DT presented the report to the Committee. The three most reported incidents through DATIX in Quarter 3 were noted to be blood transfusion issues, patient fall, slip or trip on the same level and communication issues. Compared to the previous quarters numbers remained consistent. DT noted overall the FT benchmarks adequately against no harm, low harm, and moderate/severe harm. Incidents reported by Division noted Medicine and Integrated Care to be dropping significantly, compensated by Anaesthetics, Diagnostics and Surgery where numbers have slightly increased. LAE recognised this information and noted work is ongoing around the disparity. Discussion was held regarding blood transfusion incident reporting. This has been discussed at Committee previously. A review will be brought back to Committee again.	

No.	Agenda Item	Action
	The FT complies well with requirements regarding Duty of Candour. There has been one breach of an ongoing difficult case where the Care Quality Commission (CQC) considered they were under an obligation to formally review. Formal feedback is awaited. Good processes were noted for the review of clinical claims received in Quarter 3. DT referenced the 'episodes of sickness related to musculoskeletal injuries' which have shown an increase in Quarter 3. The Health and Safety Committee are looking at how staff training on patient moving and handling can be addressed and improved. The radiation incidents reported externally to the Medicines and Healthcare Products Regulatory Agency were discussed. DT noted the radiation related incidents noted in the report were not considered an area of concern. Changes to the Ionising Radiation (Medical Exposure) Regulations are being made and staff will be full briefed as appropriate.	
Q.1.18.11	**Our Quality Plan 2018/19** TC noted the Quality Plan 2018/19 had been written to support the FT's Clinical Service Strategy and bring plans in line with the CQC's regulatory framework. This sets out the background and the principles which will collectively develop the FT's approach to understanding quality during 2018/19. The current approach to this was provided to improve quality across the FT. TC noted the document had been compiled following one of the 'Moving to Good' events recently attended. The clinical services strategy describes the ambition around clinical services with quality of services, embedded within, over the next financial year. The year long plan describes the current position with Committee dashboards looking at quality, current initiatives, goals and aims. TC requested the Committee's endorsement of the document in order this can be discussed at the FT's Let's Talk Event being held on 1 February 2018. By the end of next year it is envisaged a detailed four year strategy will be finalised, following contributions from the whole of the organisation. Considerable discussion took place. The targets set will be monitored and measured in order to understand the progress of quality. TC noted a monthly Quality report will be produced for the Quality Committee. LS informed the Committee the Health Foundation are looking for bids of up to £100,000 per bid in their latest round to support the use of data for patient care and benefits. This was noted by the Committee. The document received Committee approval and notification of outcomes in the future will be provided.	
Q.1.18.12	**Quality Impact Assessment Report** The report had been produced following an internal audit review presented at the Audit and Assurance Committee, to ensure adequate processes are in place. LAE updated the Committee on the process for identification and management of potential risk to healthcare, associated with improvement work, undertaken as part of the Trust Improvement Programme. The document explained the process assessing against criteria the impact of any suggested changes noting	

No.	Agenda Item	Action
	the impact from a quality point of view, identifying, escalating and mitigating any risks. Impact assessments consider risks to safety, effectiveness, experience, responsiveness, leadership management and any other changes to the way the FT uses information. Any identified risks are managed via the Trust Improvement Committee with escalation to the Executive Directors. The Committee noted the impressive document detailing the robust process.	
Q.1.18.13	**Patient First Sub-Committee Report** SS discussed the report noting the achievements and challenges for the group going forward. Three meetings arranged during 2017 were not quorate and hence were cancelled, due to some members having left the organisation and their replacements not having commenced in post. One of the meetings that was cancelled was shortly after EPR go-live. The quorum for meetings was noted to be 60% of members. SS noted the work undertaken around membership and engagement which has led to an improvement and SS agreed an attendance grid by month would be produced in future reports with core and co-opted members being clearly identified. Membership of the Committee will be reviewed. The revised Terms of Reference for the Patient First Sub-Committee will be submitted to the March Quality Committee for approval.	Chief Nurse
Q.1.18.14	**Leadership Walkround Update** The paper provided an update on the progress of the leadership walkrounds from October to December 2017. LAE noted the three key prompt questions used to facilitate conversations with staff and patients: • What three things are you most proud of?/What do you do well? • What is your biggest challenge?/What patient or staff issues cause you concern in relation to quality and safety? • What could you do better to improve quality and safety for patients and staff?/What can you do to change some of the challenges into positives? AP requested feedback where appropriate to the Non-Executive Directors who undertook the walkround on any issues raised and a copy of the previous walkround report being available prior to the area being visited, if a previous visit to that area had been undertaken. LAE will feed back this request.	Medical Director
Q.1.18.15	**ProGRESS report** DT discussed the ProgRESS report, a methodology used to provide assurance on compliance of fundamental standards. The FT had been invited, as one of the Trusts in the North of England, to be part of the NHS Improvement led 'Moving to Good' programme. An opportunity had arisen through the programme to utilise the resource of inviting in a number of experts to the organisation to spend a day to act as 'critical' friends in a number of areas they were asked to review. The areas were selected where the FT was aware concerns were apparent and areas where the FT considered a good quality service was provided. The outcomes were noted in Appendix 1. The Committee noted some areas of concern including theatres, however, a Quality Summit has since been organised and actions are underway.	

No.	Agenda Item	Action
	The report was noted by the Committee.	
Q.1.18.16	**Risk Assessment for Venous Thromboembolism (VTE)** LAE updated the Committee on the progress to date made in VTE assessment following the previous presentations to the Committee in October and December 2017. A weekly meeting is held by the Medical Director's Office in order the standards are resolved by the extended deadline of 31 March 2018. High level data looking at wards, departments and patients are now circulated on a weekly basis to ward teams. The Committee noted the report. FR advised a VTE section will be required in the quality report as part of the annual report.	
Q.1.18.17	**Mortality Sub-Committee Report** LAE discussed the Mortality Sub-Committee quarterly report, updating the Committee on the work that has been progressed to implement the mortality improvement programme in the FT between July 2017 and January 2018. The programme of work had involved a multi-faceted approach enabling a standardised, organised and transparent process on how mortality review is undertaken. The FT's target for completion of mortality reviews using the structured judgement review method is currently set at 25%. Following the implementation of EPR 13% is being achieved and it was noted this is a huge achievement which surpasses that of a number of local organisations. The Committee noted the success in terms of engagement and ownership linking into a more systematic approach.	
Q.1.18.18	**Paediatric Stabilisation Deep Dive**  Q.1.18.18 - Paediatric Stabilisatio Kay Rushforth (KR), Head of Nursing, Children's Services, and Dr Shaun Gorman (SG), Consultant Paediatrician, were welcomed to the meeting. KR outlined paediatric stabilisation and noted the following: • The facilities were moved to a new ward in March 2017, which included the facility for two paediatric stabilisation beds. • The two-bedded facility admitted children requiring Level 2 critical care (high dependency care) and Level 3 critical care (basic intensive care for children requiring intubation, ventilation and transfer to a paediatric Intensive Care Unit (ICU)). • One to one nursing is required. In October 2014 the CQC highlighted the following concerns during their visit: • Inadequate numbers of qualified, trained and experienced nurses competent to care for the deteriorating/ventilated child.	

No.	Agenda Item	Action
	• Incomplete weekly/daily equipment checks. • Nurses not trained for ventilator set up and checks of competency. • The FT had previously had an SI where an endotracheal tube had become dislodged and required urgent replacement. The Anaesthetic team had been recalled back to the stabilisation area but as a consequence of this the infant had suffered harm. It was considered the FT had not worked to put procedures in place to prevent such an incident reoccurring in the future. A standard operating procedure is now in place for both care in the stabilisation area and the resuscitation area in the Accident and Emergency Department and transfer from Accident and Emergency to ICU. The Committee were informed an Anaesthetist remains with the patient at all times until the Embrace transport team arrive and assume care of the infant prior to leaving hospital and that this does put additional pressure on the anaesthetic team. Not all children require intubation and ventilation but a request is always made to ask that an Anaesthetist attends the child. If the child does not need intubating the Anaesthetist does not remain with the child. The following were discussed: • Assurances. • Training Matrix. • Patient Data. • Work undertaken around the deteriorating child. • Vapotherm machines are available enabling infants with respiratory problems to be treated much earlier. From the statistics available fewer infants are now requiring stabilisation. • The priority of Risk Management and Governance around stabilisation. • The high turnover of staff and the current vacancies. • Concerns with staff training due to the reducing numbers of infants requiring stabilisation. The Committee noted: • The successful work undertaken to date. • The adequate response time from the Anaesthetists but the level of concern with the team and colleagues about maintaining skills and the expectation of specialism in the particular fields of work. • Anaesthetic teams are based in adult intensive care, time spent with the children removes Anaesthetists from their core area of work. Concerns have been voiced of being pulled between the two areas whilst maintaining levels of skills and expertise. DT will discuss this at a future Executive Management Team meeting. • Work is underway with Neonatologists, Paediatricians and Anaesthetists to determine who is best placed to intubate infants. The issue is being picked up by the Surgical and Anaesthesia Forum. • Roles and responsibilities of BTH and Embrace teams are clear when Embrace attend BTH. • The enormous amount of work around skill mix, training plans and standard operating procedures, the latter being written, as and when required, with the risk teams. • Concerns over charity monies having to be utilised to purchase Vapotherm machines. SG and KR were thanked for their attendance.	Director of Governance and Corporate Affairs

No.	Agenda Item	Action
Q.1.18.19	**Board Assurance Framework** Full discussion took place on the dashboard and the key risks.	
Q.1.18.20	**Any Other Business** Q.1.12.20.1 – As this was MI's last meeting, LS thanked MI for all his input into the Quality Committee over the tenure of his post and wished him well in the future.	
Q.1.18.21	**Matters to Escalate to the Corporate Risk Register** There were no matters to escalate to the Corporate Risk Register.	
Q.1.18.22	**Matters to Escalate to the Board of Directors** • Emergency Care Standard • Risk Management • 'Our Quality Plan 2018/19' • VTE • Mortality Report • Paediatric Stabilisation	
Q.1.18.23	**Items for Corporate Communications** There were no items for Corporate communications.	
Q.1.18.24	**Date and time of next meeting** Wednesday 28 February 2018, 2 pm to 4 pm, Conference Room, Field House, Bradford Royal Infirmary.	

Bradford Teaching Hospitals NHS Foundation Trust

BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST
ACTIONS FROM QUALITY COMMITTEE – 31 January 2018

Date of Meeting	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
20.12.17	Q.12.17.17	**Annual Governance review of the Terms of Reference for Sub-committees of the Quality Committee:** DT stated that her team would contact the Chairs of the sub-committees and ask them to consider if their membership is appropriate and if they are able to deliver on their Terms of Reference.	Director of Governance and Corporate Affairs*	28/02/18	
20.12.17	Q.12.17.18	**Board Assurance Framework**: DT referred to the previous agenda item regarding the sub-committees and asked if this should be reflected within the BAF. It was agreed that DT, KD and BG should meet with the Assistant Director of Governance and Risk to consider this and report back to the Committee.	Director of Governance and Corporate Affairs*	28/02/18	
31.01.18	Q.1.18.6 Q.1.18.7	**Information Governance Report** **Senior Information Risk Owner 2017/18 Quarter 3 Update:** LS noted the best practice audit was raised at the Informal Council of Governors meeting. CF will be invited to their next meeting to discuss.	Trust Secretary	28/02/18	Actioned 12/02/18. Item concluded.
31.01.18	Q.1.18.6 Q.1.18.7	**Information Governance Report** **Senior Information Risk Owner 2017/18 Quarter 3 Update:** LS raised the issue of the change of a patient record for those individuals who have undergone gender reassignment. CF will check the process is aligned with national guidance.	Director of Informatics	28/02/18	

Date of Meeting	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
31.01.18	Q.1.18.14	**Leadership Walkround Update:** AP requested feedback where appropriate to the Non-Executive Directors who undertook the walkround on any issues raised and a copy of the previous walkround report being available prior to the area being visited, if a previous visit to that area had been undertaken. LAE will feed back this request.	Medical Director	28/02/18	
20.12.17	Q.12.17.5	**A&E Deep Dive:** KD agreed to support a bid by the A&E team to the Charitable Funds for the acquisition of 'super trolleys' to enhance what is currently provided within the department.	Chief Nurse	28/03/18	
20.12.17	Q.12.17.6	**Quality Committee Dashboard:** CF to consider with her team how to develop the dashboard to record: The key risks, issues, and patient outcomes from 'deep dive' presentations received by the Committee to enable a review of progress against expected outcomes over time. The factors key to Bradford and its development as a young entrepreneurial city that the Foundation Trust might be able to capitalise on or should take account of.	Director of Informatics	28/03/18	
31.01.18	Q.1.18.13	**Patient First Sub-Committee Report:** Membership of the Committee will be reviewed. The revised Terms of Reference for the Patient First Sub-Committee will be submitted to the March Quality Committee for approval.	Chief Nurse	28/03/18	

Date of Meeting	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
31.01.18	Q.1.18.18	**Paediatric Stabilisation Deep Dive:** Anaesthetic teams are based in adult intensive care, time spent with the children removes Anaesthetists from their core area of work. Concerns have been voiced of being pulled between the two areas whilst maintaining levels of skills and expertise. DT will discuss this at a future Executive Management Team meeting.	Director of Governance and Corporate Affairs	28/03/18	
31.01.18	Q.1.18.8	**Urgent Care Recovery Plan:** The report was noted by the Committee and it was agreed that Quarterly Reports would be presented to this Committee.	Acting Chief Operating Officer	25/04/18	
20.12.17	Q.12.17.13	**Maternity Improvement Programme Action Plan:** KD advised there was full agreement that excellent progress had been made and that concerns had been addressed. A meeting would take place in six months to assess the position. KD to feed back to the Committee the outcome of the meeting	Chief Nurse	27/06/18	

***TITLES ALTERED TO REFLECT DIRECTOR PORTFOLIO CHANGES 8/1/2018**