Bradford Teaching Hospitals
NHS Foundation Trust

**Board of Directors:** **10.5.18**
**Agenda Item:** **Bo.5.18.26**

# Confirmed Quality Committee Minutes
# February & March 2018

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| **Presented by:** | Laura Stroud, Chair | **Author:** | Sheridan Osbourne, Corporate Governance Officer |
| **Previously considered by:** | Quality & Safety Committee | | |

| **Key points** | **Purpose:** |
|---|---|
| Quality Committee minutes 28 February & 28 March 2018 | To note |

| **Executive Summary** |
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| Quality Committee minutes 28 February & 28 March 2018 |

| **Financial implications:** |
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| No |

| **Regulatory relevance:** |
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| **Monitor:** | |

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| **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)<br>Yes ☐ No ☒<br>If yes, what is the mitigation against this? |

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| **Other:** | |

| | |
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| **Strategic Objective:** *Reference to Strategic Objective(s) this paper relates to* | To provide outstanding care for patients |
| | Choose an item. |
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Bradford Teaching Hospitals
NHS Foundation Trust

**QUALITY COMMITTEE**
**MINUTES, ACTIONS & DECISIONS**

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| **Date:** | Wednesday 28 February 2018 | **Time:** | 14:00-16:35 |
| **Venue:** | Conference Room, Field House, Bradford Royal Infirmary | **Chair:** | Professor Laura Stroud<br>Non-Executive Director |
| **Present:** | **Non-Executive Directors:**<br>- Professor Laura Stroud, Non-Executive Director (LS)<br>- Mr Amjad Pervez, Non-Executive Director (AP)<br><br>**Executive Directors:**<br>- Ms Donna Thompson, Director of Governance and Corporate Affairs (DT)<br>- Ms Cindy Fedell, Director of Informatics (CF)<br>- Ms Karen Dawber, Chief Nurse (KD)<br>- Dr Bryan Gill, Medical Director (BG) | | |
| **In Attendance:** | - Prof Clive L Kay, Chief Executive (CLK)<br>- Ms Jacqui Maurice, Head of Corporate Governance (JM)<br>- Ms Juliet Kitching, EA, Trust Headquarters (Minutes) | | |

| No. | Agenda Item | Action |
|---|---|---|
| **Q.2.18.1** | **Apologies for Absence**<br>- Mr Jon Prashar, Non-Executive Director (JP)<br>- Ms Selina Ullah, Non-Executive Director (SU) | |
| **Q.2.18.2** | **Declaration of Interests**<br>There were no declarations of interest. | |
| **Q.2.18.3** | **Minutes and Actions of the Quality Committee meeting held on 31 January 2018**<br>The minutes were accepted as a correct record, however, the Committee agreed that on page 1 of the Minutes the names of Mrs Sally Scales and Dr LeeAnne Elliott, would be moved from 'In Attendance' to under 'Present - Executive Directors'. | |
| **Q.2.18.4** | **Matters Arising**<br>The Committee noted that the following actions had been concluded.<br>Q.12.17.17 (20.12.17) – Annual Governance review of the Terms of Reference for Sub-committees of the Quality Committee.<br>Q.12.17.18 (20.12.17) – Board Assurance Framework.<br>Q.1.18.6/Q.1.18.7 (20.12.17) – Information Governance Report/Senior Information Risk Owner 2017/18 Quarter 3 Update.<br>Q.1.18.6/Q.1.18.7 (20.12.17) – Information Governance Report/Senior Information Risk Owner 2017/18 Quarter 3 Update.<br>Q.1.18.14 (31.01.18) – Leadership Walkround Update.<br>Q.12.17.5 (20.12.17) – A&E Deep Dive.<br>Q.12.17.6 (20.12.18) – Quality Committee Dashboard.<br>Q.1.01.18 (31.01.18) – Patient First Sub-Committee Report.<br>Q.1.18.18 (31.01.18) – Paediatric Stabilisation Deep Dive. | |

| No. | Agenda Item | Action |
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| | LS noted paragraph 3 of Q.1.18.11 where the Health Foundation is now open for bids up to £100,000 to support the use of data for patient care, but was unsure of the closing date. LS offered assistance with any input and CF agreed to look at this further. | Director of Informatics |
| **Q.2.18.5** | **Quality Committee Dashboard**<br>LS presented the Quality Committee dashboard and recognised from some strategic risks and actions the outstanding care being provided within some key areas.<br><br>Discussion was held with regards to the following:<br>• Death rates – The Foundation Trust (FT) reports well against Peers. Results from Structured Judgement reviews are fed back through the Mortality Sub-Committee. Recent presentation to the Health and Wellbeing Board for Airedale and Bradford on learning from deaths across the system was well received.<br>• Venous Thromboembolism (VTE) – Results are improving following recent focus on improvement and access to daily/weekly VTE performance (a value added factor from the Electronic Patient Record (EPR)). Targeted work is taking place with the small number of outlier wards/specialties.<br>• Falls with harm – Work is currently in hand following the relaunch of the falls work. An increase in the use of falls devices continues to be apparent. Areas of correlation are under consideration.<br>• Catheter associated Urinary Tract Infections – No major issues noted. The newly appointed Nurse Consultant in Infection Control will take this work forward looking at current documentation and outcomes as part of the annual work plan. Outcomes have been noted to be similar, raising possible recording issues rather than changing practice. KD noted a piece of work has recently commenced and will run to June 2018, around the nursing care plan and nursing documentation involving the offices of the Chief Nurse and the Director of Informatics. The issues of clear pathways of care required, timelines and monitoring were raised. KD noted there are some clearly defined protocols of best practice around enhanced recovery. Overarching Key Performance Indicators around length of stay, broken down by individual conditions for length of stay are available. Over the next twelve months of developing the Quality plan there will be an opportunity to receive frontline engagement on monitoring and areas for improvement.<br>• Night-time transfers – The Finance and Performance Committee meeting also discussed this indicator. The Chief Operating Officer is already reviewing the transfer of data to ensure it is correct. The appropriateness of night-time transfers was discussed. It was agreed that CF will review the indicator and consider if the indicator should be 'Inappropriate Night-Time Transfers'.<br>• Theatres – BG noted the recent Theatre Quality Summit meetings to discuss the whole programme of work. DT noted the organisational development team are working with the team using the resources of GE Finnamore Healthcare, regarding theatre productivity. The work programme will include looking at how to promote good practice and team dynamics. The key areas of aspirations, productivity and efficiencies were noted. The work being undertaken within the Quality Summit programme was noted.<br><br>The report was noted by the Committee. | |

| No. | Agenda Item | Action |
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| **Q.2.18.6** | **Information Governance (IG) Report**<br>CF discussed the report and highlighted the key headlines, following the quarterly report last month in which there was an in depth review. CF noted that training is now at 91%. The Trust is expected to reach the required level of 95% by the end of March 2018. Regular updates are being provided to managers to facilitate this work. CF also noted that the IG Toolkit is on track for completion and there is an Internal Audit review taking place that will provide feedback prior to submission of the Toolkit. CF noted that some elements of the Toolkit have improved compared to last year, following the implementation of recommendations from the Information Commissioner's Office Best Practice review.<br><br>The Committee noted the report. | |
| **Q.2.18.7** | **Serious Incident (SI) Report**<br>BG noted there had been six new SIs reported during January 2018, three related to hospital acquired pressure ulcers which continue to have a root cause analysis completed and are presented to the pressure ulcer Root Cause Analysis panel meeting.<br>The three remaining SIs were noted as follows:<br>• 2018/596 – Loss of sight.<br>• 2018/2300 – Mortuary misidentification of fetus – The incident at the time generated anxieties with processes given the national and long standing profile around management and disposal of bodies and tissues. BG highlighted the work of the Assistant Director of Governance and Risk and the support of the FT's religious leaders with the two families involved around the interments. Immediate changes were put in place to this manual system. No correspondence has yet been received back from the Human Tissue Authority in relation to the incident. LS commended the FT on the reassurances that at the time of the incident the families were immediately informed.<br>• 2018/2512 – Pulmonary embolism. With regard to the immediate actions taken, the Committee agreed the doctor should be accountable for patients' assessments for VTE. Each ward has a list of patients who should have a VTE assessment and prompts are evident on the EPR.<br><br>A proposal was also raised that the ward pharmacist confirms with the medical team of all at risk patients, who are not prescribed anticoagulants when not required and this was agreed by the Committee.<br><br>There were no reports expected to be concluded in January 2018.<br><br>BG asked the Committee to note the further extension requested for the investigation into the intrauterine death with abnormal umbilical artery Doppler, due to the limited availability of the external expert to visit the FT and complete their investigation.<br><br>The Committee noted the report. | |
| **Q.2.18.8** | **Accident and Emergency Care Quality Commission (CQC) Patient Survey Report 2017**<br>KD advised that this report had been produced in January 2018 and a further update was due in March 2018. The Accident and Emergency patient survey | |

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| | took a sample of patients from October 2016 to March 2017. KD stated that the results were disappointing with the FT performing 'worse than expected' when compared to other Trusts in the survey. KD stated that a different management team is now in place. At the time of this survey works were also being completed in the Accident and Emergency Department. A change in the Matron has brought focus on quality and safety of patients and an action plan is submitted quarterly to the Patient First Sub-Committee. KD stated that updates will be provided to the Committee, in the future, as an appendix to the Patient Experience report.<br><br>The Committee noted that KD and CF have met with the company who developed the Freedom to Speak Up app recently to consider an app which would provide information for specific conditions. A system for more live feedback was welcomed by the Committee and it was suggested that the company may be able to develop this. LS noted the actions and mechanisms in place to enhance improvement. | |
| **Q.2.18.9** | **Clinical Effectiveness 2017-18 Quarter 3 report**<br>DT presented the report describing the FT's position in relation to implementation of NICE guidance, national and local clinical audit, national enquiries and the development and management of clinical guidance. Areas of risk in relation to the management of external recommendations, national audit, local audit and use of clinical guidance were described and mitigation identified.<br><br>DT noted the FT is an outlier around NICE guidance for rheumatoid arthritis. BG had recently met with a new Consultant Rheumatologist who discussed potential new plans for the service and a business case is currently being written linked to non-obstetric ultrasound and ultrasound scanning for early arthritis.<br><br>DT highlighted issues with national audits and data quality for example the lung cancer audit where results have dipped significantly, and the sepsis audit. Assurance is being sought through the Clinical Audit and Effectiveness Committee. The chair added concerns about the paediatric diabetes audit.<br><br>CF is exploring technical solutions with a potential supplier in order to provide audit data routinely and prior to data submission. CLK noted collation of data for the upper gastrointestinal audit. CF also noted that the Governance and Business Intelligence teams have been commissioned to look at data quality of external submissions to make improvements in the data quality.<br><br>DT agreed to update the Committee at the March meeting on the lung cancer, paediatric and sepsis and severe shock audits.<br><br>DT discussed compliance of Trust-wide and local guidelines which are managed through the effectiveness team and noted concerns around guidelines in the Women and Children's Division. Regular reports are submitted to the Executive Management Team in terms of progress. Committee discussions will be fed back to the Divisions.<br><br>The Committee noted the report. | Director of Governance and Corporate Affairs |
| **Q.2.18.10** | **Freedom to Speak Up Quarter 3 Report**<br>KD provided an update on the FT's Freedom to Speak Up campaign in Quarter | |

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| | 3 and year to date which included the latest Quarter 3 national data. At BTHFT there is an increasing percentage of non-safety concerns. The FT has a good incident reporting system for patient safety and governance.<br><br>An internal audit review of the system of Freedom to Speak Up was undertaken providing assurance around the processes in place. KD noted a review meeting of the Guardians will take place in April. Awareness raising events are scheduled to take place throughout the year.<br><br>The Committee noted the report. | |
| **Q.2.18.11** | **Pathology Joint Venture Update**<br>BG noted the Clinical Director's report was submitted to the Joint Venture Board in February which pulled together quality metrics around the Pathology service.<br><br>BG noted the key highlights:<br>• The Airedale turnaround times for histopathology and Bradford turnaround times are broadly similar.<br>• An improving service is now being provided with many indicators demonstrating good performance.<br>• The Clinical Director is working on future models for histopathology and pathology across West Yorkshire.<br>• Monitoring and reporting will continue to the Joint Venture Board.<br>• Integrated Team - The Committee welcomed the positive report noting parameters and benchmarks for governance and incident reporting which will lead to better productivity. CF agreed to look at the finance and performance metrics.<br><br>LS noted the degree of assurance and questioned how this should be presented to other Committees. Follow-up reports will be submitted quarterly to the Quality Committee after the Joint Venture Board.<br><br>The Committee noted the report and the assurances on processes adopted. | Director of Informatics |
| **Q.2.18.12** | **Patient Experience Report Quarter 3 2017-18**<br>KD noted the key headlines:<br>• A complaints section is noted at the end of the report highlighting other elements of patient experience.<br>• Progress noted of the strategic workplan.<br>• Work underway by the Patient and Public Involvement Facilitator.<br>• Acute Neonatal Unit has received 'Baby Friendly' accreditation and UNICEF UK Baby Friendly accreditation. The Committee congratulated the team.<br>• PRASE (Patient Reporting and Action for a Safe Environment) was discussed where volunteers interview patients using electronic mobile devices to record their feedback. A standard feedback report is generated when twenty questionnaires are completed in an area. PRASE is currently running on Wards 9, 22, 28, 29 and the Paediatric Unit. Over the next three months PRASE will be trialled in Wards F5/F6, F7/F8, F4 and the Accident and Emergency Department. BG recommended PRASE be introduced on Ward 6 and will discuss this at the next Sentinal Stroke National Audit Programme meeting.<br>• A new Patient Experience Intranet site for engagement with staff across the | Medical Director |

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| | FT will soon be freely accessible by all FT staff along with a public internet site.<br>• Always Events – The FT continues to plan and develop a set of Always Events to improve patient discharge. The final design and pre-launch event has been scheduled for March 2018 to include Allied Health Professionals and non-clinical staff. The Patient First Committee is monitoring progress. Following the event the FT will run a relaunch of the #Hellomynameis campaign. LS noted assistance with sourcing recordings/pod casts if required.<br>• Complaints data overview – An increase in requests to the Patient Advice and Liaison Service was noted resulting in a slight increase in complaints. Comparison of Quarter 2 versus Quarter 3 data has identified an increase in appointment related complaints and less complaints relating to care and treatment. This is being monitored.<br>• One Parliamentary Health Service Ombudsman complaint in Quarter 3 was not upheld.<br>• Complaints – Only 50% of complaints have been replied to within the agreed timescales. Matrons, who write the majority of complaints, are now working on wards in the mornings to assist with patient flow. There is a focus for the FT to discuss timescales for complaint responses with patients. Performance will be improved with better communication. A template is completed six months following a complaint response noting any changes made.<br>• Lessons learnt.<br>• NHS Choices.<br>• Friends and Family Test – Alternative ways of collecting data are being explored.<br><br>The comprehensive report was noted. | |
| **Q.2.18.13** | **Report on the quality of Stroke Care**<br>BG noted the lengthy paper triggered by the BTH report from the Sentinal Stroke National Audit Programme (SSNAP) for the period August to November 2017, showing a deterioration from the previous report at Level D to Level E, reporting the measure of the care process from the admission to discharge of patients with a diagnosis of a stroke. A report is provided every four months to help drive improvements.<br><br>The Committee noted the recent presentations to the Quality Committee by the team. A weekly stroke service improvement group has subsequently been put in place, chaired by BG, and a series of immediate actions have been agreed to improve the provision of stroke care. This meeting does not include colleagues from Airedale, however, this is proposed for the future. A visit to an exemplary unit will be undertaken shortly and consideration to commission an independent, external, comprehensive review of the service will be considered.<br><br>The reasons for the deterioration in the SSNAP performance is multifactorial including the lack of staff seeing the link to the SSNAP data and delivery of stroke care and the fact that the anticipated improvements in the functioning of the new stroke ward alongside appointments of new staff have not been realised. BG noted the complexity of SSNAP data, how this is recorded and information extracted. Difficulties of general staffing/therapy recruitment into the stroke service were also highlighted. | |

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| | The Committee noted the report highlighting the team should not feel their work is not valued with support provided where necessary. All aspects are now under careful consideration to help understand the service and a recovery plan is being put in place which it is advised should include the Airedale stroke service. The report was noted with regular reports on progress to be provided to the Quality Committee. | |
| **Q.2.18.14** | **Patients First Sub-Committee Terms of Reference Review**<br>KD noted the revised Terms of Reference for the Patient First Committee and queried the Chairmanship of the Committee. The Committee advised the Chief Nurse should provide mentorship, coaching and specialist advice, in her capacity to the Sub-Committee.<br><br>KD noted some meetings were not quorate, however, associate and core membership is now clearly defined and a proposal has been made to have a patient representative as part of the Committee going forward.<br><br>The Terms of Reference were agreed subject to change to Chairmanship. | |
| **Q.2.18.15** | **Patient Safety Sub-Committee Report**<br>BG presented the report highlighting the work undertaken since July 2017 identifying the key achievements, challenges and risks being managed by the Sub-Committee. LS requested a more comprehensive dashboard is developed linked to the Committee dashboard and assurance around patient safety issues arising from staffing levels. KD noted that from the quality of care delivered no patient safety risks are identified. KD also noted that the number of European workers leaving the United Kingdom has had no impact on nurse staffing levels in the FT. BG noted the involvement of a member of the Informatics team on the sub-Committee would be helpful to enhance analysis of safety via EPR.<br><br>The Committee noted the report. | |
| **Q.2.18.16** | **Nurse Staffing Data Publication Report – January 2018**<br>KD noted this paper is submitted to the Workforce Committee which meets bi-monthly and to the Quality Committee for information on assurance on safety and quality of care. The report provides details of planned versus actual staffing levels for registered nurses/midwives and care staff for January 2018. Robust monitoring remains in place with a daily overview of the staffing in each area to maintain safety.<br><br>KD highlighted:<br>• Sickness absence rates are increasing.<br>• Fill rates noted over recruiting and overfilling in Healthcare Assistant roles.<br>• Fill rates are reduced in registered nurse posts.<br>• Heat map data to be produced by ward area over a six month timescale from April 2018.<br><br>BG raised the issue of Allied Health Professionals (AHP) and other staff groups for which the Quality Committee does not receive any specific data, to consider the impact on service safety or effectiveness of gaps in the workforce. | Chief |

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| | The Committee agreed the report be expanded to include the number of whole time equivalents for each AHP clinical scientist group from the April 2018 report, with key objectives identified and linked as appropriate to strategic objectives.<br><br>The report was noted. | Nurse/ |
| **Q.2.18.17** | **Dementia Annual Report – February 2018**<br>KD discussed the Dementia Annual Report with the BTH Dementia Framework 2017-2021 having been developed taking into account:<br>• The national priorities outlined in the Prime Minister's Challenge on Dementia 2020 (2015).<br>• The local picture outlined in the Bradford Dementia Needs Assessment (2015).<br>• Bradford Districts Dementia Strategy aligning to the strategic direction and action driven by the NHS Dementia Well Pathway.<br><br>The Committee noted the proposals and the action plan which is being picked up by the Chief Nurse's Office until the vacant Lead Nurse for Dementia post is filled.<br><br>The report was noted and the team were commended. | |
| **Q.2.18.18** | **Review Sub-Committee Terms of Reference of the Quality Committee**<br>DT discussed the changes to the sub-Committee structures and the revised Terms of Reference which included a change to reporting mortality through a subgroup of the Clinical Audit and Effectiveness Committee ensuring effective management.<br><br>The Terms of Reference of the Patients First Committee will be amended as approved earlier in the meeting. BG proposed under the Patient Safety Sub-Committee the Resuscitation Group be renamed the Deteriorating Patient Group and this was agreed.<br><br>From the annual point of reviewing the Terms of Reference the documentation was approved. | Director of Governance and Corporate Affairs/Trust Secretary |
| **Q.2.18.19** | **Treat As One – Bridging the Gap between Mental and Physical Healthcare in General Hospital National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Guidance 2017**<br>NCEPOD issued guidance in 2017 relating to the care of patients with mental health conditions in a District General Hospital. The FT has a requirement to review the recommendations and implement any relevant changes or learning. The action plan and the briefing note were noted. A working group has been established to further develop the guidance. Regular audits are being undertaken and strategies developed.<br><br>KD reported work is already underway in Departments to look at how practices can be improved and a six month progress report will follow.<br><br>The report was noted by the Committee. | Chief Nurse/ Trust Secretary |
| **Q.2.18.20** | **Board Assurance Framework**<br>Full discussion took place on the dashboard and the key risks. | |

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| **Q.2.18.21** | **Any Other Business**<br>Q.2.18.21.1 – On behalf of the Committee LS thanked DT for all her work and input over the years and wished her a long, healthy and happy retirement. | |
| **Q.2.18.22** | **Matters to share with other Committees**<br>• Workforce issues.<br>• Links to other Committees including Finance and Performance.<br>• Identification on reports to the appropriate strategic objective. | |
| **Q.2.18.23** | **Matters to Escalate to the Corporate Risk Register**<br>There were no matters to escalate to the Corporate Risk Register. | |
| **Q.2.18.24** | **Matters to Escalate to the Board of Director**<br>There were no matters to escalate to the Board of Directors. | |
| **Q.2.18.25** | **Items for Corporate Communications**<br>The UNICEF UK Baby Friendly accreditation was noted to have been featured in Let's Talk. | |
| **Q.2.18.26** | **Date and time of next meeting**<br>Wednesday 28 March 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 – 28 February 2018**

| Date of Meeting | Agenda Item | Required Action | Lead | Timescale | Comments/Progress |
|---|---|---|---|---|---|
| 28.02.18 | Q.2.18.4 | **Matters Arising:** LS noted paragraph 3 of Q.1.18.11 where the Health Foundation is now open for bids up to £100,000 to support the use of data for patient care, but was unsure of the closing date. LS offered assistance with any input and CF agreed to look at this further. | Director of Informatics | 28/03/18 | |
| 28.02.18 | Q.2.18.9 | **Clinical Effectiveness 2017-18 Quarter 3 report:** DT agreed to update the Committee at the March meeting on the lung cancer, paediatric and sepsis and severe shock audits. | Director of Governance and Corporate Affairs | 28/03/18 | Deferred to April meeting |
| 28.02.18 | Q.2.18.11 | **Pathology Joint Venture Update:** Integrated Team - The Committee welcomed the positive report noting parameters and benchmarks for governance and incident reporting which will lead to better productivity. CF agreed to look at the finance and performance metrics. | Director of Informatics | 30/05/2018 | |
| 28.02.18 | Q.2.18.12 | **Patient Experience Report Quarter 3 2017-18:** BG recommended PRASE be introduced on Ward 6 and will discuss this at the next Sentinal Stroke National Audit Programme meeting. | Medical Director | 28/03/18 | |
| 28.02.18 | Q.2.18.16 | **Nurse Staffing Data Publication Report – January 2018:** The Committee agreed the report be expanded to include the number of whole time equivalents for each AHP clinical scientist group from the April 2018 report, with key objectives identified and linked as appropriate to strategic objectives. | Chief Nurse | 25/04/2018 | |

| Date of Meeting | Agenda Item | Required Action | Lead | Timescale | Comments/Progress |
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| 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 | 28/03/2018 | 28/02/18: Item added to the work plan. Action concluded |
| 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 | 28/02/18: KD updated on the Maternity Improvement Action Plan. KD, Dr Janet Wright and some of the Maternity Team have met with Prof Jimmy Walker around him challenging the plans in order assurance can be obtained. KD will forward to Prof Walker the minutes. Prof Walker will write to CLK with an update from that meeting. Prof Walker did not express any immediate concerns but a number of actions were noted in order to improve services further. CLK will then write to LS. LS will then submit to the Board of Directors. |
| 28.02.18 | Q.2.18.18 | **Review Sub-Committee Terms of Reference of the Quality Committee:** The Terms of Reference of the Patients First Committee will be amended as approved earlier in the meeting. BG proposed under the Patient Safety Sub-Committee the Resuscitation Group be renamed the Deteriorating Patient Group and this was agreed. | Director of Governance and Corporate Affairs/Trust Secretary | 28/03/18 | ToR updated. Action concluded |
| 28.02.18 | Q.2.18.19 | **Treat as One: NCEPOD** KD reported work is already underway in Departments to look at how practices can be improved and a six month progress report will follow. | Chief Nurse/ Trust Secretary | 29/08/18 | Added to August 2018 agenda. |

Bradford Teaching Hospitals
NHS Foundation Trust

**QUALITY COMMITTEE**
**MINUTES, ACTIONS & DECISIONS**

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| **Date:** | Wednesday 28 March 2018 | **Time:** | 14:00-16:30 |
| **Venue:** | Conference Room, Field House, Bradford Royal Infirmary | **Chair:** | Professor Laura Stroud<br>Non-Executive Director |
| **Present:** | **Non-Executive Directors:**<br>- Mr Amjad Pervez, Non-Executive Director (AP)<br>- Mr Jon Prashar, Non-Executive Director (JP)<br>- Professor Laura Stroud, Non-Executive Director (LS)<br>- Ms Selina Ullah, Non-Executive Director (SU)<br><br>**Executive Directors:**<br>- Dr Tanya Claridge, Assistant Director Governance and Risk, (TC) representing Ms Donna Thompson<br>- Ms Cindy Fedell, Director of Informatics (CF)<br>- Dr Bryan Gill, Medical Director (BG)<br>- Ms Sally Scales, Deputy Chief Nurse, (SS) representing Ms Karen Dawber<br>- | | |
| **In Attendance:** | - Mrs Sarah Goleby, Service Support Manager (Minutes)<br>- Professor Clive L Kay, Chief Executive (CLK)<br>- Ms Jacqui Maurice, Head of Corporate Governance (JM)<br><br>For item **Q.3.18.6 only**<br>- Dr Ahmed Zayat, Consultant Rheumatologist/Clinical Lead<br>- Ms Corinne Jeffrey, Divisional General Manager, Medicine and Urgent Care<br>- Ms Catherine Short, Rheumatology Nurse Specialist<br>- Dr Sarah Twigg, Consultant Rheumatologist | | |

| No. | Agenda Item | Action |
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| **Q.3.18.1** | **Apologies for Absence**<br>- Ms Donna Thompson, Director of Governance and Corporate Affairs (DT)<br>- Ms Karen Dawber, Chief Nurse (KD) | |
| **Q.3.18.2** | **Declaration of Interests**<br>There were no declarations of interest. | |
| **Q.3.18.3** | **Minutes and Actions of the Quality Committee meeting held on 28 February 2018**<br>The minutes were accepted as a correct record. | |
| **Q.3.18.4** | **Matters Arising**<br>The Committee noted that the following actions had been concluded:<br>Q.2.18.4 – CF advised that bids would be submitted to the Health Foundation.<br>Q.2.18.12 – Patient Experience Report Quarter 3 2017/18.<br>Q.1.18.8 – Urgent Care Recovery Plan.<br>Q.2.18.8 – Review of Sub-Committee Terms of Reference.<br>Q.2.18.19 - Treat as One: NCEPOD, added to August agenda.<br><br>Updates were provided against the following actions: | |

| No. | Agenda Item | Action |
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| | Q.2.18.9 – Clinical Effectiveness 2017/18 Quarter 3 report deferred to April Meeting.<br><br>Q.2.18.6 – Nurse Staffing Data Publication Report – SS advised that the report structure had been reviewed and a request was made to the Committee to accept the submission of a separate report covering Allied Health Professional staffing data starting Quarter 1. This would be presented to the Committee in July. This proposal was accepted. | |
| **Q.3.18.5** | **National Institute for Health and Care Excellence (NICE) Guidance on Rheumatoid Arthritis: Compliance and Issues**<br>Dr Zayat delivered a comprehensive presentation which covered the main requirements of the clinical guideline (CG79). The presentation provided the outcome of the National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis identifying both regional and individual hospital compliance. The Rheumatology team felt that improvements could be made if a number of issues were addressed. These were outlined in the presentation.<br><br>There was a wide ranging discussion which included particular questions about the audit data, the risks to patients, mitigation and service improvements.<br>• It was confirmed that not all data had been included in the audit but a member of the team had been identified for the next round and it was expected that a more complete audit would be undertaken.<br>• Delays in treatment affected the quality of life for patients but there were some types of issues that if treated earlier, it was likely that the patient would be in remission.<br>• The population of Bradford presented a more complex case mix and there were some high risks. However the data did not include Lupus and Vasculitis.<br>• There had been a number of factors that affected underperformance. One of these had been the move to central booking. Prior to that the team had been able to be reactive to the lists.<br>• Staffing issues were discussed and it was acknowledged that recruitment was very difficult and had been for a number of years. This was a national picture and the Trust had been very lucky in the past to recruit internally. However, regional workforce solutions are likely to need to be considered for the population.<br>• The Division was aware of the difficulties and delays in the service and it was included in the Divisional Risk Register and Strategy. There had been three changes in management over a short period of time and the service would benefit from some stability.<br>• The Electronic Patient Record (EPR) was presenting opportunities for changing the ways of working and a useful piece of work was completed with the Clinical Commissioning Groups to change the pro forma. There was some ongoing work with General Practitioners with special interests that could filter patients and start treatment at an earlier stage.<br>• It was agreed that a strategy for the service (aligned to our clinical strategy) needed to be made that took into consideration regional working so that staffing issues were not centred on one city or hospital.<br>• The team implied that patients could be harmed by the delays in meeting NICE guidance. BG advised that this specific issue is considered at the | Medical Director |

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| | Patient Safety Sub-Committee which the Medical Director will action.<br><br>The Chair thanked the team for providing the Committee with a clear picture of the service and the difficulties in meeting the targets set by NICE guidelines. It was agreed that BG would discuss some of the points raised at a future meeting with the Rheumatology team and a deep dive will be presented to the Committee.<br><br>There was an extended discussion regarding presentations to the Committee: how they were selected; whether they should include dashboards; how follow-up is monitored to ensure triangulation and whether a standard presentation template should be used. It was pointed out that the Rheumatology presentation was not a standard deep dive but the team had been asked to attend specifically to discuss NICE guidance (although the actual presentation covered many other aspects).<br><br>CLK advised that many of the presentations covered operational issues, which could prove difficult to address when the Chief Operating Officer was not a member of the Committee. These issues could be picked up by the Finance and Performance Committee. It was noted that all presentation were first made at the Executive Management Team meeting.<br><br>It was agreed that TC, BG, and CF would meet to discuss the structure of the presentations and possible metrics.<br><br>Major changes have been made to monitoring and assurance of data through the Clinical Assurance and Effectiveness Committee (CAEC) and TC advised that she was confident that exceptions were identified as the data on compliance is now available. Full risk assessments are completed and risks included on the risk register. The Commissioners have confirmed that they are assured by the data that is provided to them. It was agreed that Dr Paul Smith (Chair of CAEC) would be invited to a future Quality Committee.<br><br>A recommendation should be given for the Chairman to include triangulation of data (linked with presentations) in a future Board Development Session. | Medical Director<br><br>Assistant Director of Governance and Risk/ Medical Director/ Director of Informatics<br><br>Director of Governance and Corporate Affairs<br><br>Director of Governance and Corporate Affairs |
| **Q.3.18.6** | **Quality Committee Dashboard**<br>The Dashboard was reviewed and the following areas picked out for in depth discussion:<br><br><u>Management of Venous Thromboembolism (VTE)</u>: Significant progress had been made in VTE assessments but work is ongoing to identify why there are still some assessments that are not being completed. A particular area under scrutiny is ward 5 where 75% of the patients do not require a VTE assessment, as they are not at risk. However, de-selecting is difficult. A medical led action plan has been put in place to meet the 95% target. Daily VTE reports are received and a working group meets weekly. A full update report was received by the Committee under a later agenda item.<br><br><u>Falls with Harm</u>: The work being undertaken by the wards that have the greater number of incidents continues, using the improvement methodology. One of the difficulties with the data is that it covers all harm, including very low harm, | |

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| | bruising etc and, therefore, it can prove difficult to identify improvement. Ward staff should continue to report all incidents but a reduction in high or severe harm would be the indicator of improvement. Consideration should be given to changing the way the data is presented.<br><br>Pressure Ulcers: A reduction in numbers of Category 3 is being realised. The improvement work with the wards continues and root cause analyses (RCA) are completed. Monthly monitoring is undertaken and reported through the Quality of Care Panel (QuOC). Additional support and focus is on the wards with the higher numbers of reported incidents. Risk assessments are completed on admission and a review of the prompts available through EPR is being undertaken. Discussion takes place with patients or their relatives and leaflets are handed out providing information on how pressure ulcers can be avoided. Any lapses in care identified through the RCAs are acted on to ensure learning, and any themes identified addressed through amendments to training. It would be helpful to see the number of avoidable incidents separated out from unavoidable, to identify improvements in care.<br><br>Risk assessments on falls and pressure ulcers have been changed to include moving and handling issues. | |
| **Q.3.18.7**<br>**Q.3.18.8** | **Information Governance Report**<br>**Information Governance Toolkit**<br>CF presented reports on the above and highlighted that mandatory information governance training compliance reached 95% during March 2018.<br><br>The Trust has completed the annual Information Governance Toolkit (IGT). Internal Audit had sampled ten requirements in the IGT and provided a 'significant' assurance option.<br><br>The Chair acknowledged the excellent achievement in the training compliance and the Committee approved the submission of the Information Governance Toolkit on behalf of the Board of Directors. | |
| **Q.3.18.9** | **Serious Incident Report**<br>BG advised that there had been two new serious incidents declared during February; one of these was in relation to a pressure ulcer. The other incident related to a patient who suffered harm following two falls. The patient died five days after the falls. Immediate actions were highlighted in the report but BG commented that the report did not reflect the seriousness of the patient's condition. A full investigation will be undertaken.<br><br>A request had been made to the Clinical Commissioning Group (CCG) to de-log the incident involving the absconding of a patient. The placing of the patient was appropriate and they escaped through a fire escape and were found very quickly following the sounding of the alarm. The patient was found on the fire escape leading to the roof-top. A response was awaited from the CCG.<br><br>A full incident report was presented and discussed. This was a high risk, complex surgical procedure. The surgery on the day was prolonged and technically difficult. The team fully considered, with the patient, the risks involved in going ahead with the procedure but the investigation identified that communication with the family members could have been better and | |

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| | documentation, including recording consent, the second consent required improvement.<br><br>As the report indicated that this type of procedure is rarely performed nationally, not just at BTHFT, a discussion took place regarding whether cases of this nature should be referred to other hospitals. It was confirmed that the case was fully discussed at the Multi-Disciplinary Team Quality and Safety meeting for the specialty. BG agreed to raise this issue with other Medical Directors in the area.<br><br>The Chair raised a matter that had been discussed in patient/public forums and had recently received publicity - whether procedures were carried out for the right reasons and not for financial incentives. BG advised that 'Get it Right First Time' looks at comparators, outcomes and variations. The West Yorkshire programme is specifically concentrating on hip and knee surgery but are expecting to cover every specialty in due course. Extracting data and the outcome of the reports will be discussed with clinical colleagues at a future time-out. | Medical Director |
| **Q.3.18.10** | **Bradford Accreditation Scheme (BAS)**<br>The paper described the progress of the scheme and it was noted that thirty-four wards and departments are now participating. SS advised the meeting that the table on page 5 had been updated but the narrative had not, similarly the graph in section 3. An updated copy would be provided.<br><br>The next steps were outlined in the report and this included reviewing and refreshing the assessment documentation. The assurance team were looking at developing spots checks and it was expected that outcome of these would be fed into the accreditation process.<br><br>Where any assessments were rated red, urgent action plans were put in place and re-assessment was arranged within a three month time-scale. Issues that came out of the assessments were discussed at the daily huddles held in the Risk Department to allow triangulation of data. Where leadership issues were identified the individuals are provided with support and their responsibilities clarified.<br><br>It was noted that some areas had poor Sentinal Stroke National Audit Performance but had been rated green. It was acknowledged that this was a starting point focussed predominantly on aspects of nursing care, but over time it was expected that it would become more inclusive.<br><br>The Chair thanked SS for her report and the work that was being undertaken, accepting that there was further work to be done to be able to provide full assurance. | Chief Nurse |
| **Q.3.18.11** | **Security Management Standards**<br>This item was deferred to a future meeting. | Director of Finance |
| **Q.3.18.12** | **Mandatory Training Compliance**<br>The Committee was asked by the Board of Directors to further review the approach to the mandatory training standards for the Trust. Following presentation of the report by BG the Committee re-affirmed its view that the approach to mandatory training levels was approved as it was assured by the | |

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| | balanced approach and the safety nets around new starters and refresher training. This will be reported through to the Board of Directors by the Quality Committee.<br><br>TC advised that she would be meeting with Care Quality Commission (CQC), together with the Head of Training, to understand their expectations on end of year reporting.<br><br>The Committee noted the key points and were assured by the ongoing work outlined in the report. | Chair |
| **Q.3.18.13** | **Infection Prevention and Control Report**<br>SS presented the report covering the period November 2017 to February 2018. It was noted that there had been one attributable MRSA bacteraemia in January 2018 and a total of four cases since April 2017. Six cases of C.difficile had been reported during the period, with a year to date total of 17 against a target trajectory of 51.<br><br>Claire Chadwick, Nurse Consultant Infection Prevention, had recently been appointed and as audits had identified poor compliance in some standards/areas there will be a 'back to basics' focus on areas such as dress code, hand hygiene and aseptic non-touch technique (ANTT). | |
| **Q.3.18.14** | **Management of Venous Thromboembolism (VTE) Update on Progress**<br>The content of the report was noted and assurance gained. Discussion had taken place under item Q.3.18.6. | |
| **Q.3.18.15** | **Briefing Paper: Trust Research Committee Update – March 2018**<br>BG advised that the paper had been submitted whilst he was on leave and unfortunately it did not meet the intended purpose. Bradford Institute for Health Research needs to provide the Quality Committee with regular updates on the work undertaken by them to meet the Research Strategy and programme of research. This will be included in future reports. | Medical Director |
| **Q.3.18.16** | **Draft Quality Report**<br>JM advised the Committee that the Quality Report formed part of the Annual Report and Accounts. Sections one and two were mandated and very prescriptive. Section three is more narrative and should reflect Patient and Public Involvement.<br><br>The timetable for the report had been set out by the Audit and Assurance Committee. This was an opportunity for review and comment by the members of the Quality Committee prior to presentation to external stakeholders.<br><br>There were a few significant sections being added before the end of the week and an updated report would be circulated as quickly as possible.<br><br>Comments were requested by 8 April 2018 to JM. | |
| **Q.3.18.17** | **Development of a real time quality dashboard – Cerner**<br>BG provided a verbal update on the development of a real time quality dashboard. He advised that he had been in contact with Cerner but it would take some time before anything would be available and he would provide further | Medical |

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| | updates no later than in six months' time. | Director |
| **Q.3.18.18** | **Nurse Staffing Data Publication Report – February 2018**<br>The report is presented to the Quality Committee monthly and the Workforce Committee bi-monthly. Monitoring is by exception and the Trust is continuing to see a number of challenges. There is a lot of time spent monitoring staffing levels and moving staff to different wards to ensure patient safety.<br><br>It was noted that less than 80% staffing for more than three months was increasing. | |
| **Q.3.18.19** | **Trust-wide Combined Learning Report Quarter 3 2017/18**<br>During Quarter 3 the Trust remained focussed on the continued safe implementation of EPR and preparation for the anticipated CQC inspection. One of the benefits of this was that all EPR risks were closely monitored. Positive comments were received from Cerner and our staff understood what was required from them.<br><br>The report provided the learning outcomes from significant events, including a large piece of work in relation to VTE; a focus on mortality, and near misses regarding thickening agents.<br><br>Learning comes from a number of areas:<br>• At a senior level, cascaded from incidents submitted to QuOC . There is an established system where a Rapid Response Alert is issued for anything of significance.<br>• There is a daily huddle in the Risk Department which asks:<br>o Were we safe yesterday?<br>o Are we safe today?<br>o Will we be safe tomorrow?<br>This is attended by the risk team, and staff employed by the Divisions in risk related roles.<br>• The Learning Hub, where learning comes from a number of different sources.<br>• Member of the Risk team attend the matron/ward huddles and take back learning to the department.<br><br>The Chair thanked TC for her report and stated that it was explanatory and descriptive and provided a high level of assurance for the Committee. | |
| **Q.3.18.20** | **Quality Improvement Programme**<br>BG advised the Committee that the projects are targeted but can be applied throughout the Trust. Improvements take time before results are seen but there are threads of improvement, for example Grade 3 pressure ulcers, already identified within other reports presented to the Committee.<br><br>The work being undertaken through the programme was acknowledged and noted. | |
| **Q.3.18.21** | **Quality Committee Business Work plan 2018-19**<br>The meeting was asked to carefully consider the business work plan and feedback any comments or requests for additions. | All |

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| | It was agreed that the plan would be approved at the April meeting. | Head of Corporate Governance |
| **Q.3.18.22** | **Board Assurance Framework**<br>The members of the Committee confirmed that they had considered the report and had gained assurance from the data provided.<br><br>TC advised that she was working with KD and BG to progress some of the corporate risks. This should provide a higher level of assurance in the future. | |
| **Q.3.18.23**<br>**Q.3.18.23.1** | **Any Other Business**<br>BG advised that the Maternity and The Royal College of Obstetricians and Gynaecologist report had been shared with a legal firm who were pursuing a claim with the Trust. They had shared the reports with the Yorkshire Post who had contacted the Trust for comment. It was possible that there would be further interest from the regulators and other areas of the media should the Yorkshire Post go to publication. A meeting had taken place to meet the needs of any patient concerns if publication went ahead.<br><br>The Committee noted the actions being taken. | |
| **Q.3.18.24** | **Matters to share with other Committees**<br>• Finance and Performance - Get it Right First Time. | |
| **Q.2.18.25** | **Matters to Escalate to the Corporate Risk Register**<br>There were no matters to escalate to the Corporate Risk Register. | |
| **Q.3.18.26** | **Matters to Escalate to the Board of Director**<br>There were no matters to escalate to the Board of Directors. | |
| **Q.3.18.27** | **Items for Corporate Communications**<br>There were no matters for Corporate Communications. | |
| **Q.3.18.28** | **Date and time of next meeting**<br>Wednesday 25 April 2018, 2.30 pm to 4.30 pm, Conference Room, Field House, Bradford Royal Infirmary. | |

Bradford Teaching Hospitals
NHS Foundation Trust

**BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST**
**ACTIONS FROM QUALITY COMMITTEE – 28 March 2018**

| Date of Meeting | Agenda Item | Required Action | Lead | Timescale | Comments/Progress |
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| 28.02.18 | Q.2.18.9 | **Clinical Effectiveness 2017-18 Quarter 3 report:** DT agreed to update the Committee at the March meeting on the lung cancer, paediatric and sepsis and severe shock audits. | Director of Governance and Corporate Affairs | 25/04/18 | On April Agenda. Action concluded. |
| 28.03.18 | Q.3.18.5 | **NICE Guidance on Rheumatoid Arthritis: Compliance and Issues** The team implied that patients could be harmed by the delays in meeting NICE guidance. BG advised that this specific issue is considered at the Patient Safety Sub-Committee which the Medical Director will action. | Medical Director | 25/04/18 | 18.04.18: Rheumatology invited to Patient Safety Sub-Committee. |
| 28.03.18 | Q.3.18.5 | **NICE Guidance on Rheumatoid Arthritis: Compliance and Issues** Operational Issues - It was agreed that TC, BG, and CF would meet to discuss the structure of the presentations and possible metrics. | Assistant Director of Governance and Risk/Medical Director/Director of Informatics | 25/04/18 | 04.04.18: CF – This item has been completed. Action concluded. |
| 28.03.18 | Q.3.18.10 | **Bradford Accreditation Scheme (BAS)** The paper described the progress of the scheme and it was noted that thirty-four wards and departments are now participating. SS advised the meeting that the table on page 5 had been updated but the narrative had not, similarly the graph in section 3. An updated copy would be provided. | Chief Nurse | 25/04/18 | 12.04.18 – Completed by S Scales, Deputy Chief Nurse, document sent to Head of Corporate Governance. Action concluded. |
| 28.03.18 | Q.3.18.11 | **Security Management Standards** This item was deferred to a future meeting. | Director of Finance | 25/04/18 | Added to April agenda. Action concluded. |

| Date of Meeting | Agenda Item | Required Action | Lead | Timescale | Comments/Progress |
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| 28.03.18 | Q.3.18.12 | **Mandatory Training Compliance**<br>The Committee was asked by the Board of Directors to further review the approach to the mandatory training standards for the Trust. Following presentation of the report by BG the Committee re-affirmed its view that the approach to mandatory training levels was approved as it was assured by the balanced approach and the safety nets around new starters and refresher training. This will be reported through to the Board of Directors as the Quality Committee. | Chair | 25/04/18 | |
| 28.03.18 | Q.3.18.21 | **Quality Committee Business Work plan 2018-19**<br>Carefully consider the business work plan and feedback any comments or requests for additions<br><br>Add to April agenda for approval. | All<br><br>Head of Corporate Governance | 25/04/18 | Added to April Agenda. Action concluded. |
| 28.02.18 | Q.2.18.11 | **Pathology Joint Venture Update:**<br>Integrated Team - The Committee welcomed the positive report noting parameters and benchmarks for governance and incident reporting which will lead to better productivity. CF agreed to look at the finance and performance metrics. | Director of Informatics | 30/05/18 | 28.03.18: It was agreed to move this to the Finance and Performance action plan. Action concluded. |
| 28.03.18 | Q.3.18.5 | **NICE Guidance on Rheumatoid Arthritis: Compliance and Issues**<br>The Chair thanked the team for providing the Committee with a clear picture of the service and the difficulties in meeting the targets set by NICE guidelines. It was agreed that BG would discuss some of the points raised at a future meeting with the Rheumatology team and a deep dive will be presented to the Committee. | Medical Director | 30/05/18 | |

| Date of Meeting | Agenda Item | Required Action | Lead | Timescale | Comments/Progress |
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| 28.03.18 | Q.3.18.15 | **Briefing Paper: Trust Research Committee Update – March 2018**<br>Bradford Institute for Health Research needs to provide the Quality Committee with regular updates on the work undertaken by them to meet the Research Strategy and programme of research. This will be included in future reports. | Medical Director | 30/05/18 | |
| 20.12.17 | Q.12.17.13 | **Maternity Improvement Programme Action Plan:**<br>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 | 28/02/18: KD updated on the Maternity Improvement Action Plan. KD, Dr Janet Wright and some of the Maternity Team have met with Prof Jimmy Walker around him challenging the plans in order assurance can be obtained. KD will forward to Prof Walker the minutes. Prof Walker will write to CLK with an update from that meeting. Prof Walker did not express any immediate concerns but a number of actions were noted in order to improve services further. CLK will then write to LS. LS will then submit to the Board of Directors. |
| 28.03.18 | Q.3.18.5 | **NICE Guidance on Rheumatoid Arthritis: Compliance and Issues**<br>It was agreed that Dr Paul Smith (chair of CAEC) would be invited to a future Quality Committee. | Director of Governance and Corporate Affairs | 27/06/18 | Will be picked up by new Trust Secretary following appointment in June 2018. |
| 28.03.18 | Q.3.18.5 | **NICE Guidance on Rheumatoid Arthritis: Compliance and Issues**<br>A recommendation should be given for the Chairman to include triangulation of data (linked with presentations) in a future Board Development Session. | Director of Governance and Corporate Affairs | 27/06/18 | Will be picked up by new Trust Secretary following appointment in June 2018. |

| Date of Meeting | Agenda Item | Required Action | Lead | Timescale | Comments/Progress |
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| 28.03.18 | Q.3.18.9 | **Serious Incident Report**<br>BG to raise rarely performed complicated procedures with other Medical Directors in the area to identify a common approach. | Medical Director | 27/06/18 | |
| 28.02.18 | Q.2.18.16 | **Nurse Staffing Data Publication Report**<br>The Committee agreed a separate report Q1 would be presented covering Allied Health Professionals, with key objectives identified and linked as appropriate to strategic objectives. | Chief Nurse | 25/07/18 | |
| 28.03.18 | Q.3.18.17 | **Development of a real time quality dashboard – Cerner**<br>BG provided a verbal update on the development of a real time quality dashboard. He advised that he had been in contact with Cerner but it would take some time before anything would be available and he would provide further updates no later than in six months' time. | Medical Director | 26/09/18 | |