Bradford Teaching Hospitals
NHS Foundation Trust

Board of Directors: **12.7.18**
Agenda Item: **Bo.7.18.30**

Confirmed Quality Committee Minutes
25 April 2018 & 30 May 2018

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

Key points	**Purpose:**
Quality Committee minutes 25 April 2018 & 30 May 2018	To receive

Executive Summary
Quality Committee minutes 25 April 2018 & 30 May 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 COMMITTEE
MINUTES, ACTIONS & DECISIONS

Date:	Wednesday 25 April 2018	**Time:**	14:00-16:30
Venue:	Conference Room, Field House, Bradford Royal Infirmary	**Chair:**	Professor Laura Stroud Non-Executive Director
Present:	**Non-Executive Directors:** - Mr Amjad Pervez, Non-Executive Director (AP) - Professor Laura Stroud, Non-Executive Director (LS) - Ms Selina Ullah, Non-Executive Director (SU) **Executive Directors:** - Dr Tanya Claridge, Director of Governance and Corporate Affairs (TC) - Dr Bryan Gill, Medical Director (BG) - Dr Paul Southern, Associate Medical Director (PS) representing Ms Cindy Fedell, Director of Informatics (CF) - Ms Sally Scales, Deputy Chief Nurse (SS) representing Ms Karen Dawber, Chief Nurse (KD) - Mr Matthew Horner, Director of Finance (MH) in attendance for Agenda item Q.4.18.11		
In Attendance:	- Ms Jacqui Maurice, Head of Corporate Governance (JM) - Ms Juliet Kitching, PA (Minutes)		

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Q.4.18.1	**Apologies for Absence** - Mr Jon Prashar, Non-Executive Director - Ms Cindy Fedell, Director of Informatics - Ms Karen Dawber, Chief Nurse	
Q.4.18.2	**Declaration of Interests** There were no declarations of interest.	
Q.4.18.3	**Minutes and Actions of the Quality Committee meeting held on 28 March 2018** The minutes were accepted as a correct record.	
Q.4.18.4	**Matters Arising** The Committee noted that the following actions had been concluded: Q.3.18.5 (28.03.18) – NICE Guidance on Rheumatoid Arthritis: Compliance and Issues. Q.3.18.5 (28.03.18) – NICE Guidance on Rheumatoid Arthritis: Compliance and Issues. Q.3.18.10 (28.03.18) – Bradford Accreditation Scheme. Q.3.18.11 (28.03.18) – Security Management Standards. Q.3.18.12 (28.03.18) – Mandatory Training Compliance. Q.3.18.21 (28.03.18) – Quality Committee Business Work plan 2018-19. Q.2.18.11 (28.02.18) – Pathology Joint Venture Update. Q.3.18.5 (28.03.18) – NICE Guidance on Rheumatoid Arthritis: Compliance and Issues.	
Q.4.18.5	**Quality Committee Work plan 2018-19**	

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	LS drew the Committee's attention to the proposed 2018/19 work plan for the Quality Committee. BG tabled a copy of a letter received from Max McLean, Chair of the Joint Quality Committee, Bradford and Airedale Clinical Commissioning Group (CCG), to LS requesting a meeting with members of the Quality Committee concerning potential quality issues relating to the following services – Accident and Emergency performance, Referral to Treatment (RTT) times, Cancer targets, Maternity services, Bacillus Calmette–Guérin (BCG) vaccinations and stroke, to share intelligence and gain assurance where required. The Committee noted some of the areas were not items regularly considered at the Quality Committee but agreed to accept this invitation. The Committee may need to broaden membership to this meeting to the Chair of the Finance and Performance Committee and invite other Non-Executive representation. The cross-referencing and ways of working between Committees was raised and an oversight system was discussed. The report was noted by the Committee.	
Q.4.18.6	**Integrated Quality: Board Dashboard – 31 March 2018** The Quality Dashboard was reviewed and the following noted: Further work is being undertaken on the metrics of the Board Quality Dashboard with monthly reporting. For the last three months the Foundation Trust (FT) is consistently maintaining good Venous Thromboembolism (VTE) assessment performance and has been successful in its application to be part of a national collaborative to reduce pressure ulcers. A mini collaborative piece of work is underway around falls in wards and departments. This has resulted in improvements in some areas in the last month. A safety culture in Theatres continues to be developed and the theatres team will present to the Quality Committee as part of the Quality Summit process.	
Q.4.18.7	**Quality Oversight System Profile and Outcomes – March 2018** TC explained that the Quality oversight system had been implemented as a management system to support the operational oversight of quality within the organisation. The focus of the system is to ensure effective processes are in place to manage risks and issues on a day to day basis. The principles and the elements of the system were noted along with the following from March 2018: • Daily risk review and daily risk huddle occurred on 100% of required days. • Eighteen incidents were referred to the Quality of Care Panel. • Twenty-two incidents were referred to the Incident Performance Management Group. • The active surveillance areas for the system mirror the areas raised earlier which the CCG wish to discuss. • A Quality Summit in Haematology will be held in April. • Regular reports from the Quality Summits will continue to be fed back to the	

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	Quality Committee.
	• Stroke: Weekly meetings continue to support improvement work. Following discussion the CCG have committed to support the programmed development of a single stroke service between Airedale and Bradford, with the appointment of a programme manager. BG is working closely with the Chief Operating Officer.
	• The Accident and Emergency Quality Summit process is nearing completion and it is anticipated that there will be sufficient evidence for it to be signed off by the Quality Committee in September/October.
	• The Theatres Quality Summit process is continuing and developments are expected to be presented to the Quality Committee in late 2018.
	• Concerns in Maternity continue to be monitored and the forthcoming joint Quality meeting with the CCG will provide an opportunity to explore the effectiveness of the improvement plan.
	• Assurance in the following areas were discussed:
	  • RTT and non-RTT: a clinical advisory panel will be established to support identification and management of risk
	  • No rapid response alerts have been issued.
	  • The Committee noted poor behaviours can be picked up through the Freedom to Speak Up process, however, the confidential nature of information provided was highlighted. In depth qualitative issues relating to quality and safety are discussed and contextualised at the Quality of Care Panel meeting.
	
	LS thanked TC for her report and noted oversight system information will be discussed with other Non-Executive Directors at a forthcoming Board Assurance Framework (BAF) development session.
		Chief Nurse

Q.4.18.8	**Serious Incident (SI) Report** TC advised there had been three new SIs reported by the Foundation Trust during March 2018 with two of the incidents reported as occurring within the Maternity Service. One related to escalation and management of antenatal and perinatal complications. One incident related to missing antenatal screening results for twenty-two women, following the routine quarterly quality assurance process around all antenatal screening. Data was initially identified as missing for ten women, however, on further investigation a further twelve women were found to have no results. The incidents were discussed and immediate actions have been put in place where necessary. A further recent SI in Maternity, regarding a retained vaginal swab, has been declared as a Never Event during April 2018. A further incident was reported as occurring in the Accident and Emergency Department and relates to an unexpected death. The FT has received approval from the CCG to de-log an investigation which involved a patient who absconded on to the roof. Two SIs had been concluded and submitted to the CCG in March, one concerning an intrauterine death, from August 2017, which was subject to an independent investigation and raised system issues, the demand on the service and delivery and team culture working. One related to a delay in the diagnosis of oral cancer, due to the route by which the patient was referred into the FT. This will be an issue for	

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	discussion at the joint Quality meeting with the Clinical Commissioning Group. The report was noted by the Committee.	
Q.4.18.9	**Quarterly Risk Management Report** TC reported incident reporting overall remains consistent. A summary of the incidents that were required to be reported to external agencies were noted. The learning associated with incidents had been removed from the paper and will be included in a combined learning paper that is now included quarterly in the Committee's work plan. A profile of the assurance associated with the effectiveness of action planning following a SI was presented. TC noted a link and described actions related to the outcome of the 2017 staff survey, also presented to the Workforce Committee, relating to improving incident reporting. Frequently reported incidents were noted not to have changed, however, TC proposed to look at the top five incidents in a different way, for instance continued consideration of blood transfusion incidents revealed predominantly transcription errors, ie no harm incidents. Concern was identified with the lack of progress made around incidents relating to patient discharge. Learning matters continue to be developed as per the schedule. Medication incidents were noted to have reduced. The risk team continues to proactively assess any risk relating to the implementation of the Electronic Patient Record (EPR), the management of deteriorating patients, any harm related to waits in Accident and Emergency and delays in appointments/diagnosis. TC noted a number of challenging inquests scheduled this quarter may result in publicity. The report was approved by the Committee.	
Q.4.18.10	**Serious Incident Investigations: The Changing National Picture** TC alerted the Committee to the changing national picture around investigations. The Healthcare Safety Investigation Branch (HSIB), established in 2017 are beginning to investigate incidents meeting pre-defined criteria including all maternity incidents relating to Each Baby Counts. BG noted the FT own these investigations, if undertaken by an external body, and the embedding of recommendations may prove a challenge. NHS Improvement is consulting on the National Serious Incident Framework. The Committee agreed to the recommendations of the report: • The Quality of Care Panel adds the consideration of a referral to the HSIB for incidents potentially meeting their criteria to their decision matrix when assessing the investigation level for an incident. • Once the FT is included in the phased implementation of the programme to investigate maternity incidents related to 'Each Baby Counts' babies, the Quality Committee is notified through its regular SI Report. • The FT manages reports from the HSIB using a similar system of review, implementation and assurance that are applied to alerts from the National Patient Safety Alert System (NPSAS), and reports the response to them through the quarterly learning report received by the Quality Committee. Using a similar approach to the management and assurance associated with	

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	NPSAS alerts will also ensure that these reports are tracked through to the appropriate Sub-Committee of the Quality Committee for monitoring and assurance. • Committee members are encouraged to take part in the survey. • The Assurance Team together with Internal Audit undertake an urgent review of the processes in place in the FT to ensure that any of the contributory factors identified in the published report are not evident in our investigative process and assure the quality and consistency of the approach used. The report was approved by the Committee.	
Q.4.18.11	**Security Management Standards for Providers** MH provided an update on security management standards introduced by NHS Protect a number of years ago and the self-review tool enabling the Trust to assess compliance against standards. NHS Protect was disbanded, however, as good practice the FT retained the process to evaluate current performance against the expected standards – Strategic Governance, Inform and Involve, Prevent and Deter and Hold to Account. The standards provide assurance to commissioners in terms of compliance. There are 29 applicable standards for the FT to measure compliance with the majority achieving full compliance. For the few standards achieving partial or non-compliance individual action plans are in place. Of note a group is now in place to develop a plan around training for conflict handling, however, difficulties have arisen with clinical engagement. For assurance, the process has been shared with Commissioners and areas continue to be reviewed and action plans updated. MH agreed to provide an update in six months' time on clinically related challenging behaviour (Action 3.2). The Committee noted the report.	Director of Finance
Q.4.18.12	**Nurse Staffing Data Publication Report – February 2018 and March 2018** **Nurse Staffing Data Publication Report – February 2018 and March 2018** SS presented the March 2018 report noting the February 2018 report had been previously discussed at the March Quality and Workforce Committees. The FT continues with similar challenges relating to fill rates, particularly with registered nursing staff on the BRI site. The increased number of DATIX forms completed was noted. Twenty-four incidents recorded as no harm, four with low harm, sixteen had not been investigated at the time of producing the report. Fifteen incident reports had been completed in relation to Accident and Emergency which resulted in a focus on care standards and staffing on the Clinical Decision Unit (CDU). The standard of no less than two registered nurses in any area for safety was fulfilled in March, however, staffing challenges were faced over the Easter period. The heat map was referenced. The Acute Medical Unit ward accreditation visit assessment in February 2018 was red. Remedial actions around quality standards and accreditation are underway. Results of the Ward 12 accreditation will be available in April. Concerns had been identified regarding escalation beds on Ward 22, however, these are currently closed. A recent recruitment drive has resulted in	

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	the appointment of new staff. BG expressed concerns and anxieties on the continuing delivery of good care due to staffing levels. The leadership of the stroke ward is being separated into stroke and Hyper-Acute Stroke Unit (HASU). The report was noted by the Committee.	
Q.4.18.13	**High Priority Audit Programme 2018/19** TC presented the FT High Priority Audit Plan for 2018/19 for approval. The volume of national audits required for participation was noted. Divisional priority audits have been approved by Divisions and the Executive Management Team (EMT) to develop the programme. Proposals will be made through EMT to change the FT's approach on national audits due to the volume, capacity issues and the follow-up of actions and assurance. The National Clinical Audit process is necessary for the Quality Account along with a number of additional mandated audits, however, was noted to be hampering clinical engagement. BG noted the time delay from submitting data to receiving results can be up to eighteen months. Good practice was recognised to provide assurance around the effectiveness of services, however, TC will bring a proposal within the effectiveness report as to how these may be more simply managed. The report was noted by the Committee.	Director of Governance and Corporate Affairs
Q.4.18.14 **Q.4.18.15**	**Information Governance (IG) Report** **Senior Information Risk Owner (SIRO) Report** PS reported no Level 2 high risk incidents in Quarter 4. An investigation is underway for one incident which remains open from Quarter 3. IG training compliance reached 95% during March. The IG toolkit submitted in March 2018 was a satisfactory rating. Work to ensure compliance in incoming General Data Protection Regulation (GDPR) progresses with increased focus. A Task and Finish group is picking up all affected areas. The data quality dashboard is monitoring RTT pathways and six key indicators are being monitored by a full-time operational team seconded from their day jobs to focus on this work. The positive report was noted by the Committee. Discussion was held concerning GDPR related to carers of patients who have undergone end of life care. The Committee noted information may be obtained via the Bereavement team in order surveys can be undertaken.	
Q.4.18.16	**Leadership Walk round Update** BG presented the progress report of the leadership walk rounds from January to March 2018 noting feedback is linked to direct engagement with staff. TC noted the launch next week of forty staff undertaking monthly environmental assurance work on wards. The report was noted by the Committee.	
Q.4.18.17	**Bilateral Relationship with Airedale Foundation Trust Update** BG provided an updated to the Committee discussing quality/care aspects, healthcare complexities, governance arrangements, patient ownership, transfer of accountability outcomes, patient flow and liabilities.	

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	BG noted the CCG have now fully supported the need to look at the quantifiable and qualitative relationships that occur between our services. A programme will be set up and independently reviewed.	
Q.4.18.18	**Board Assurance Framework (BAF)** TC presented the BAF to the Quality Committee noting the BAF has been strengthened in response to actions from the last Integrated Governance and Risk Committee to improve the Framework, and results of an internal audit. The Corporate Risk Register is presented by principle risk and will form an appendix to the BAF. TC is attending all Board Committees to support the use of the BAF. A revised Committee paper front sheet has been compiled enabling direct reference to the BAF and risk appetite for the strategic objectives. The report was noted by the Committee.	
Q.4.18.19 **Q.4.18.19.1** **Q.4.18.19.2**	**Any Other Business** SU discussed a recent event held in the community where Dr Sulman Hasnie, Consultant Microbiologist, led a consultant session on organ donation. SU requested this item be featured in a future edition of Let's Talk and the Committee agreed. TC informed the Committee the FT is likely to be declaring a Never Event in Maternity services regarding a retained vaginal swab. A full report will be provided at the May Quality Committee.	 Head of Corporate Governance Director of Governance and Corporate Affairs
Q.4.18.20	**Matters to share with other Committees** • Bilateral relationship with Bradford and Airedale. • Joint Quality Meeting with nominated individuals from BTH and CCGs. • Escalation of workforce discussions and links between Committees (TC/SS/JM). • Never Event.	
Q.4.18.21	**Matters to Escalate to the Corporate Risk Register** There were no matters to escalate to the Corporate Risk Register.	
Q.4.18.22	**Matters to Escalate to the Board of Directors** There were no matters to escalate to the Board of Directors.	
Q.4.18.23	**Items for Corporate Communications** There were no matters for Corporate Communications.	
Q.4.18.24	**Date and time of next meeting** Wednesday 30 May 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 – 25 April 2018

Date of Meeting	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
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.
28.03.18	Q.3.18.5	**NICE Guidance on Rheumatoid Arthritis: Compliance and Issues** 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** 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
25.04.18	Q.4.18.13	**High Priority Audit Programme 2018/19** Good practice was recognised to provide assurance around the effectiveness of services, however, TC will bring a proposal within the effectiveness report as to how these may be more simply managed.	Director of Governance and Corporate Affairs	27/06/18	
28.03.18	Q.3.18.17	**Development of a real time quality dashboard – Cerner** 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	
25.04.18	Q.4.18.11	**Security Management Standards for Providers** MH agreed to provide an update in six months' time on clinically related challenging behaviour (Action 3.2).	Director of Finance	31/10/18	
28.03.18	Q.3.18.9	**Serious Incident Report** BG to raise rarely performed complicated procedures with other Medical Directors in the area to identify a common approach.	Medical Director	19/12/18	25.04.18: In relation to SI report discussed at the March meeting relating to the renal cancer case. Information received this is being discussed at a national level, due to the rarity of these procedures. Timescale altered awaiting for National guidance. BG to update when information available.
28.03.18	Q.3.18.15	**Briefing Paper: Trust Research Committee Update – March 2018** Bradford Institute for Health Research needs to	Medical Director	30/01/19	25.04.18: BG – Timescale adjusted to align to when the next report is due.

Date of Meeting	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
		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.			

QUALITY COMMITTEE
MINUTES, ACTIONS & DECISIONS

Date:	Wednesday 30 May 2018	**Time:**	14:00-16:30
Venue:	Conference Room, Field House, Bradford Royal Infirmary	**Chair:**	Professor Laura Stroud Non-Executive Director
Present:	**Non-Executive Directors:** - Mr Amjad Pervez, Non-Executive Director (AP) - Professor Laura Stroud, Non-Executive Director (LS) - Ms Selina Ullah, Non-Executive Director (SU) - Mr Jon Prashar, Non-Executive Director (JP) **Executive Directors:** - Dr Tanya Claridge, Director of Governance and Corporate Affairs (TC) - Dr Bryan Gill, Medical Director (BG) - Ms Karen Dawber, Chief Nurse (KD)		
In Attendance:	- David Hollings, Deputy Director of Informatics (DH) representing Cindy Fedell, Director of Informatics (CF) - Susan Franklin, Associate Chief Nurse For Quality Improvement (SF) for agenda item Q.5.18.5 - Helen Fearnley, Lead Tissue Viability Advanced Nurse Practitioner (HF) for agenda item Q.5.18.5 - Sarah Keogh, Head of Midwifery (SK) for agenda item Q.5.18.6 - John Anderson, Consultant Obstetrician & Gynaecologist (JA) for agenda item Q.5.18.6 - Ms Jacqui Maurice, Head of Corporate Governance (JM) - Mrs Sehra Hassan, Executive Assistant (Minutes)		

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Q.5.18.1	**Apologies for Absence** - Ms Cindy Fedell, Director of Informatics (CF)	
Q.5.18.2	**Declaration of Interests** There were no declarations of interest.	
Q.5.18.3	**Minutes and Actions of the Quality Committee meeting held on 25 April 2018** The minutes of the meeting were accepted as an accurate record subject to the following changes: - Q.4.18.7 (25.04.18) Quality Oversight System Profile and Outcomes – delete action - Q.4.18.19.1 (25.04.18) Any Other Business – change name and job title of Consultant.	
Q.5.18.4	**Matters Arising** The Committee noted that the following actions had been concluded: - Q.2.18.9 - Clinical Effectiveness 2017-18 Quarter 3 report - Lung Cancer, Paediatrics, Sepsis and Severe Shock Audits included within the Q3	

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	Report. Action concluded. - Q.2.18.16 - Nurse Staffing Data Publication Report. Included on the Committee agenda. Action concluded. - Q.4.18.19.1 Article covering Organ Donation featured in Let's Talk. Action concluded. - Q.4.18.19.2 (25.04.18) Any Other Business. Report regarding a Never Event in Maternity Services has been included on the agenda. Action concluded.	
Q.5.18.5	**Quality Committee Work Plan 2018-19** LS reported that since the previous meeting of the Committee, a number of members had attended a meeting with the Clinical Commissioning Groups (CCG). It was agreed that a reciprocal meeting would be arranged with the CCG for the autumn. LS confirmed that with regard to the Deep Dives, these would take place every other month.	Trust Secretary
Q.5.18.6	**Focus On: The Maternity Improvement Programme** KD introduced Sarah Keogh, Head of Midwifery (SK) and John Anderson, Consultant Obstetrician & Gynaecologist (JA) to the Committee. KD advised the meeting that the presentation they would deliver had recently been delivered to the CCGs. SK and JA delivered the comprehensive presentation which provided detailed information on improvements made since December 2017. AP commented that on the diverse nature of Bradford and its relatively young population and queried the engagement undertaken with local communities. . SK informed the Committee that there had been a re-launch of the Maternity Voice Partnership. Links had also been made with organisations working specifically with young women including asylum seekers as well as other hard to reach communities. The Committee noted SU's role as Chair of the Muslim Women's Council and it was agreed that SK would discuss with SU, outside of the meeting, potential opportunities for engagement with local community. BG asked if daily reviews were now in place with doctors who were senior decision makers. JA advised that they were not. KD confirmed that plans were now in place where a senior reviewer carried out ward rounds on a daily basis and if this did not happen this was picked up at the safety huddle which JA confirmed. KD proposed that the ongoing monitoring around the Maternity Plan is presented to the Quality Committee at a future meeting, as some additional work and assurances around the maternity plan are currently being undertaken. KD and TC will work on this and proposed an update to be provided for Quarter 1 as part of the quarterly maternity update.	Chief Nurse
Q.5.18.7	**Integrated Quality: Board Dashboard** TC reported on the excellent work on Venous Thromboembolism (VTE) in April	

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	where 94.9% of the target was achieved. She advised that a full report will be provided at the next meeting of the Committee. TC explained that a Root Cause Analysis (RTA) is undertaken for VTE and as an organisation we have not managed this consistently in the past. BG added that a lot of targeted work has been undertaken but there still is a lot to do in terms of establishing the thrombosis group. SU asked when the data quality issues resulting from the Electronic Patient Record (EPR) are expected to be resolved in order that accurate information is available. DH explained that work is ongoing to improving data quality and getting an output, but more importantly getting it right the first time when the data is entered. KD wished to thank the Infection Prevention Team, for the work they have undertaken over the past 12 months on Methicillin-Resistant Staphylococcus aureus (MRSA) and the work they have done in practice. KD explained that the team worked with Procurement in relation to cannula packs to improve technique and reduce infection.	
Q.5.18.8	**Quality Oversight System** TC explained that work has been progressing with the Quality Summit process. Improvement programmes are in place and regular updates provided from services and improving programmes. The Committee was asked to note: • Update from Maternity/Stroke. • Assurance work will commence the following month with Accident and Emergency services and their completed action plan. • The Theatres work is almost completed and a summit is taking place in September. • A mock unannounced inspection will take place over two days in the summer. BG commented that the Quality Oversight System was positive and is unique to our Foundation Trust. One of the challenges when the Care Quality Commission (CQC) visited were around the key messages to raise people's awareness and have greater confidence around shared learning. It was agreed that the Quality Oversight System would be highlighted in the report from the Committee to the Board of Directors.	Head of Corporate Governance
Q.5.18.9	**Serious Indent (SI) Report** TC provided an update on the one incident in April 2018 which was declared as a Never Event (retained swab). Immediate actions were taken and Quality of Care (QuOC) members met with the staff member involved in the incident. The Committee noted the high impact learning that had resulted from the incident. TC advised that the incident has resulted in the CQC giving notice that it would be considering enforcement action. The evidence has been collated and presented as part of the improvement plan to the CQC. TC asked the Committee to note that the CCG has agreed to delog one investigation related to an incident involving the loss of sight. The |Committee also noted that the CCG had refused to delog another incident at the	

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	requisition of the Foundation Trust related to an incident involving A&E Safeguarding. JP asked how we are getting the balance right between sharing the learning and retaining that very clear message, that this is a Never Event. TC discussed with the Committee the Never Event declared under any other Business at the meeting in April which had been fully documented in the report presented. The Never Event related to a retained vaginal swab. The Committee noted the immediate actions taken including the Rapid Response action related to the circulation of information to highlight the swab checking process to labour ward and the Bradford Birth Centre. TC responded that there was no harm to the patient and once this was understood, the seriousness of the incident was also understood. The contributing factors are being looked into and there are systems and processes in place that support this and to ensure that with staff are adequately supported. TC added that Schwartz rounds will soon begin, to encourage staff to come forward and express their feelings about an event or incident. LS referred to the contents of the sterile packs and asked if these were not optimal. TC advised that the packs had been designed quite a long time ago and they included items that staff no longer made use of. The swab used in this instance was chosen as it suited the patient whose needs were different from other patients in similar situation. TC added that 'vaginal swabs' are one of the more common Never Events reported however they have been reducing. TC provided a verbal report on a second declared Never Event related to the administration of medication by the wrong route to a patient who had required bladder irrigation. TC advised that although there was no harm to the patient it was investigated as a Never Event. A number of steps have been taken with regard to supporting the individuals involved, reviewing managerial responsibilities and, with regard to the Ward, a review instigated on the systems in place for effective ward management. KD explained that the ward where the Never Event took place was under scrutiny and subject to informal performance monitoring. LS thanked TC for her comprehensive report.	
Q.5.18.10	**Never Event: Retained Swab** This item was discussed under Q.5.18.9	
Q.5.18.11	**Never Event: Administration of medication by the wrong route** This item was discussed under Q.5.18.9	
Q.5.18.12	**Nurse Staffing Data Publication Report April 2018** KD presented the report and explained that there have been improvements in overall staffing positions: • Sickness absence has improved. • Staff feel calmer.	

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	• Escalation beds have closed. • There have been pockets of new starters but the large recruitment drive taking place will not come to fruition until September. • Triangulate harms against staffing levels to continue as part of the heat map. LS asked if there were different ways of presenting the report to ensure assurance is provided. KD explained that information is presented as a snapshot of the month and not as ward trend analysis. KD advised that the previous 12 months data will be reviewed every quarter starting from Quarter 4 and provided from July onwards as part of the nurse staffing data report.	Chief Nurse
Q.5.18.13	**Safeguarding Adults Annual Report and Safeguarding Children 2017-18** This item was taken in conjunction with agenda item Q.5.18.14. KD presented the Safeguarding Adults and Children's Report and explained that priorities and plans for next year are now being reviewed. There are no significant issues with regards to Safeguarding Children and Adults and KD was extremely proud of the work undertaken by both teams. KD highlighted the following key item from the report. KD advised of a Serious Incident in relation to Safeguarding Children where a safeguarding concern was not initially picked up in A&E but was picked up 36hrs later through the fail-safe systems. There was no harm to the child. LS asked about domestic violence around modern slavery. KD explained that some work has been done in relation to people going out of the country. SU raised a concern regarding Local Authority assessments for Deprivation of Liberty Safeguards (DoLS) and asked if this had been raised. KD confirmed that this has been raised at the Adult Safeguarding Board and is on the Local Authority Risk Register. SU asked if this had been referred to the Scrutiny Committee. KD was unsure but confirmed that she would raise this at the next Adult Safeguarding Board meeting. The recommendations presented in the reports were accepted along with the 18/19 work-plans.	Chief Nurse
Q.5.18.14	**Safeguarding Children Annual Report 2017-18** This item was covered in agenda item Q.5.18.13.	
Q.5.18.15	**Focus on Patient Harm: Pressure Ulcers** HF and SF delivered a comprehensive presentation. Following the presentation LS asked about the level of staffing and engagement with staff with regard to quality and safety issues in relation to pressure ulcers. KD advised that the team had increased from February, but the number of referrals and the acuity of patients had also increased and included a rise in the number of Elderly patients. SF explained that at times there were staffing issues with bank or agency staff but this was not	

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	significantly impacting on the quality and safety of care delivered. The level of surveillance on the front line is good and the Tissue Viability team has been strengthened with good collaborative working taking place. LS thanked HF and SF for their presentation.	
Q.5.18.16	**Clinical Effectiveness Q4 Report 2017-18** TC presented the report and asked the Committee to note the updates included which covered Sepsis, Lung Cancer and the Paediatric Diabetes Audit. TC also drew attention to the in-house audits which covered Sepsis and Sever Shock audit and the Lung Cancer Audit which both found that there were a number of standards that were not being achieved. TC advised that a number of steps have been taken to address the failings which include - Documentation review - Recognition of Sepsis by all nurses and doctors - Appropriate investigations undertaken for Lung damage. Actions for improvement will be reviewed each quarter SU asked about the number of patients diagnosed with Sepsis annually. BG reported that it stood at 5% of the population of patients that attend A&E. He asked the Committee to note that spotting Sepsis was a new challenge - the Clinical Effectiveness Committee looked at risks associated with this by exception and received quarterly reports quarter in relation to audit or concerns raised. He further advised that the Nurse Consultant for Infection Control, would be leading on improvements and to support this would be linking with all wards. LS requested that a 'deep dive' presentation on Sepsis be presented to the Quality Committee in six months and to deliver a presentation. KD advised that the CCG would also be receiving a 'deep dive' presentation on Sepsis in September and it would make sense for this to be presented to the Committee at the same time. TC provided a comprehensive overview with regard to: - The Paediatric Diabetes Audit regarding the issues identified in relation to HbA1c which identified the Trust as a negative outlier. TC advised that concrete plans and actions would be presented to the next Clinical Effectiveness Assurance Committee and following this the Quality Committee would receive a report by exception if required. - National Lung Cancer. The audit published in January, now shows that the proportion of patients seen by a specialist nurse is 34.9% which is higher than Yorkshire and Humber. Some residual concerns remain as described in Appendix 4. TC advised that the next quarterly update to the committee would include an update on the 'conduct of national audits, managing the conduct of national audit'. LS thanked TC for the comprehensive report.	Chief Nurse

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Q.5.18.17	**National Audit Update – Lung, Sepsis and Paediatric Diabetes** Item discussed in agenda item Q.5.18.6.	
Q.5.18.18	**Report on the Quality Stroke care: Quarterly update.** BG advised that The paper highlighted the progress of work that has been made in improving the SSNAP performance and ensuring that data was collected on every single stroke patient. He advised that some real progress was being made to the high level SSNAP metrics. BG asked the Committee to note the focus of the improvement was on those areas that showed the largest deterioration in the last SSNAP report. He also drew attention to table 1 and 2, where the greatest improvements had been made. BG stated that that he was hopeful that the Trust would achieve Level D in the next SNAP data report but warned the committee, that the timeframe to influence the next SSNAP data was short. BG asked the committee to note that a visit had been made to East Lancashire NHS Trust to support best practice and learning. LS requested a presentation to be provided at the next meeting of the Committee on Stroke. She further agreed that BG would share the report with the CCG to demonstrate the work that has been undertaken to date with regard to Stroke Care.	Medical Director
Q.5.18.19	**Clinical Audit Annual Report** TC provided a detailed overview of the report which described the clinical activity conducted during 207/18 at the Foundation Trust. The Committee noted and received the report.	
Q.5.18.20	**Learning from Deaths Quarterly Report** BG advised that as part of the national guidance on Learning from Deaths the Trust is required to publish information on deaths, reviews and investigations via a quarterly agenda item and paper to its public board meetings, including information on reviews of the care provided to those with severe mental health needs or learning disabilities. The committee was asked to note that due to data submission delays due to EPR implementation, the national data figures of Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) are not included within the report. This information is expected to be reported in the next quarterly report. The Committee noted that the Trust continued to monitor its own mortality data internally and review the care of patients. LS asked how the Trust celebrated the excellent practice that came from the learning. BG advised that an article had been included in Let's Talk.	
Q.5.18.21	**Information Governance (IG) Report** Work is being done to maintain the stellar training rate for IG Training. All General Data Protection Regulations (GDPR) actions are now complete. There	

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	is a high level of awareness and we have only had one incident over the last year which is very good. It was agreed that the success should be shared with staff and featured in Let's Talk. LS thanked DH for the report.	
Q.5.18.22	**Patient Experience Annual Report 2017-18 (includes Complaints and Quarter 4)** KD reported that complaints have seen similar trends to the previous quarter, with Care of Treatment being the main concern. There have been some positive trends such as an increase with more contacts with Patient Advice and Liaison Service (PALS). There has been a restructuring of the Complaints team and the PALS team have been brought together with Complaints. There has been a focus on communicating better with the public through the internet or intranet. The challenge over the last 12 months was the quality of the Trust's complaints responses due to work pressures. A mini PLACE light assessment has been introduced and the results this year are looking more encouraging. The Committee agreed that a 'Deep Dive' presentation should be made to the Committee on Patient Experience.	Chief Nurse
Q.5.18.23	**Freedom to Speak Up Annual Report (including Quarter 4 Report)** KD explained that a detailed discussion took place at the Workforce Committee meeting, around the theme of concerns that have been raised in the last year relating to harassment and bullying, with allegations proven around racism. KD discussed this with the Director of Human Resources and agreed that an action from this Committee could be to take this to the Workforce Committee as it currently sits with patient safety. The Workforce Committee should lead on issues not related to patient safety. The Committee noted that a new training guide has been produced by the National Guardian Office. A Board Assurance document on Freedom to Speak Up is due to be published. The Committee noted that effective systems were in place,which were subject to audit. It was suggested that a Board Development session is held in quarter one or two to provide an update on Freedom to Speak up.	Head of Corporate Governance Director of Governance and Corporate Affairs
Q.5.18.24	**ProgRESS Report** TC apologised for the delay in the report, as the work was suspended due to the CQC inspection. TC advised that there has been a progress review to support IG toolkit submission and Peer Review went live in April, engaging with both clinical and non-clinical staff as part of ProgRESS.	
Q.5.18.25	**Draft Internal Audit Plan** LS asked the Committee to note that the draft Internal Audit Plan was presented to the Finance and Performance Committee earlier in the day. BG noted a correction to be made 'Pharmacy and Medicine Management	Head of Corporate

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	Theatre Stock' which should be under the Chief Operating Officer". Internal Audit would be advised. The Committee noted the report and also noted that there was nothing at present that the Committee required to be added to the plan.	Governance
Q.5.18.26	**Board Assurance Framework** The Committee noted that BG and KD are working through positive and negative assurance and using that in relation to the papers that come to the Committee and to Executive Management Team.	
  Q.5.18.27.1 **A.5.18.27.2**	**Any Other Business** Breach of Duty of Candour – TC advised that the Chief Executive has received correspondence inviting him for an interview under caution under the breach of Duty of Candour. The CQC are intending to prosecute the Trust and we have been invited to write a statement under caution. This is linked to the neonatal death in the summer of 2016 and there has been some misunderstanding with the organisation and there has been no attempt to hide the incident. There was a failure to send a letter of apology as it was assumed somebody else had done it, it has been reported on through here. If there is a neonatal or any other death with complications, then an urgent Multi-Disciplinary Team meeting takes place. There has been a lot of evidence to say that we have had improvements but we could potentially be prosecuted. Duty of Candour launched again and we are to add a field to the QuOC form. SU asked if there is an official tracking process and TC explained there is a system, but there was a failure in communication. The family have challenged every step of the way. Letter from Public Health England - BG received a Letter from Public Health England which was circulated to Committee members regarding the new Microbiology Service in Pathology Joint Venture. The letter raises concern s about the quality of service. This was discussed at yesterday's Pathology Board and the JV will meet with Public Health England and report back to the Quality Committee in due course.	
Q.5.18.28	**Matters to share with other Committees** Freedom to speak up Annual Report (including Q4 Report) - To take to the Workforce Committee.	
Q.5.18.29	**Matters to Escalate to the Corporate Risk Register** Candour to take to Integrated Governance and Risk Register.	
Q.5.18.30	**Matters to Escalate to the Board of Directors** Maternity and SPI/Stroke.	
Q.5.18.31	**Items for Corporate Communications** Recognising excellent practice.	
Q.4.18.24	**Date and time of next meeting** Wednesday 27 June 2018, 2 pm - 4 pm, Conference Room, Field House, Bradford Royal Infirmary.	

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Bradford Teaching Hospitals NHS Foundation Trust

BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST

ACTIONS FROM QUALITY COMMITTEE – 30 May 2018

Date of Meeting	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
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.
28.03.18	Q.3.18.5	**NICE Guidance on Rheumatoid Arthritis: Compliance and Issues** 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 progressed by the new Trust Secretary. Timescale to be confirmed.
28.03.18	Q.3.18.5	**NICE Guidance on Rheumatoid Arthritis: Compliance and Issues** 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 progressed by the new Trust Secretary. Timescale to be confirmed.

Date of Meeting	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
25.04.18	Q.4.18.13	**High Priority Audit Programme 2018/19** Good practice was recognised to provide assurance around the effectiveness of services, however, TC will bring a proposal within the effectiveness report as to how these may be more simply managed.	Director of Governance and Corporate Affairs	27/06/18	Delivered at May Quality Committee. Action concluded.
30.05.18	Q.5.18.5	**Quality Committee Work plan 2018-19** LS reported that since the last meeting of the Quality Committee a number of members attended a meeting with the CCG's. It was agreed that a reciprocal meeting would be arranged with the CCG for the autumn.	Director of Governance and Corporate Affairs	27/06/18	Will be progressed by the new Trust Secretary. Timescale to be confirmed.
30.05.18	Q.5.18.8	**Quality Oversight System** It was agreed that the Quality Oversight System would be highlighted in the report from the Committee to the Board of Directors.	Head of Corporate Governance	27/06/18	
30.05.18	Q.5.18.18	**Report on the Quality Stroke care: quarterly update** Presentation on update on stroke	Medical Director	27/06/18	This is included on the June committee agenda. Action concluded.
30.05.18	Q.5.18.25	**Draft Internal Audit Plan** A correction to be made 'Pharmacy and Medicine Management Theatre Stock' which should be under the Chief Operating Officer". Internal Audit to be advised.	Head of Corporate Governance		
30.05.18	Q.5.18.6	**Focus On: The Maternity Improvement Programme** The Committee noted SU's role as Chair of the Muslim Women's Council and it was agreed that SK would discuss with SU, outside of the meeting, potential opportunities for engagement with local	Chief Nurse	25/07/18	

Date of Meeting	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
		community.			
30.05.18	Q.5.18.6	**Focus On: The Maternity Improvement Programme** The ongoing monitoring around the Maternity Plan will be presented to the Quality Committee at a future meeting as some additional work and assurances around the Maternity Plan is underway. KD and TC will provide an update for Quarter 1.	Chief Nurse / Director of Governance and Corporate Affairs	25/07/18	
30.05.18	Q.5.18.12	**Nurse Staffing Data Publication Report April 2018** KD advised that the previous 12 months data will be reviewed every quarter starting from Quarter 4 and provided from July onwards as part of the nurse staffing data report.	Chief Nurse	25/07/18	
30.05.18	Q.5.18.13	**Safeguarding Adults Annual Report and Safeguarding Children 2017-18** SU raised a concern regarding Local Authority assessments for Deprivation of Liberty Safeguards (DoLS) and asked if this had been raised. KD confirmed that this has been raised at the Adult Safeguarding Board and is on the Local Authority Risk Register. SU asked if this had been referred to the Scrutiny Committee. KD was unsure but confirmed that she would raise this at the next Adult Safeguarding Board meeting.	Chief Nurse	25/07/18	
30.05.18	Q.5.18.13	**Freedom to Speak Up Annual Report (including Quarter 4 Report)** KD discussed this with the Director of Human Resources and agreed that an action from this	Head of Corporate Governance	25/07/18	

Date of Meeting	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
		Committee could be to take this to the Workforce Committee as it currently sits with patient safety. The Workforce Committee should lead on issues not related to patient safety.			
30.05.18	Q.5.18.13	**Freedom to Speak Up Annual Report (including Quarter 4 Report)** It was suggested that a Board Development session is held in quarter one or two to provide an update on Freedom to Speak up.	Director of Governance and Corporate Affairs	25/07/18	Will be progressed by the new Trust Secretary. Timescale to be confirmed.
28.03.18	Q.3.18.17	**Development of a real time quality dashboard – Cerner** 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	
30.05.18	Q.5.18.16	**Clinical Effectiveness Q4 Report 217-18** Joint presentation on Sepsis to the Quality Committee and the CCG.	Chief Nurse	26/09/18	
30.05.18	Q.5.18.27	**Any Other Business** BG to give an update from meeting with Public Health England around concerns of quality of service in Pathology.	Medical Director	26/09/18	
25.04.18	Q.4.18.11	**Security Management Standards for Providers** MH agreed to provide an update in six months' time on clinically related challenging behaviour (Action 3.2).	Director of Finance	31/10/18	

Date of Meeting	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
28.03.18	Q.3.18.9	**Serious Incident Report** BG to raise rarely performed complicated procedures with other Medical Directors in the area to identify a common approach.	Medical Director	19/12/18	25.04.18: In relation to SI report discussed at the March meeting relating to the renal cancer case. Information received this is being discussed at a national level, due to the rarity of these procedures. Timescale altered awaiting for National guidance. BG to update when information available.
28.03.18	Q.3.18.15	**Briefing Paper: Trust Research Committee Update – March 2018** 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	30/01/19	25.04.18: BG – Timescale adjusted to align to when the next report is due.