Bradford Teaching Hospitals
NHS Foundation Trust

Council of Governors: 18.1.18
Agenda Item: CGo.1.18.19

Report from the Chair of the Quality Committee

Presented by:	Professor Laura Stroud, Non-Executive Director	**Author:**	Sarah Worstead, Corporate Compliance Manager
Previously considered by:	Board of Directors held 11 January 2018		

Key points	**Purpose:**
1. This paper provides a brief summary of the key matters that were discussed at the meetings of the Quality Committee held on 20 December 2017 and 29 November 2017.	To discuss and note
2. The confirmed minutes from the Quality Committee meetings held on 25 October 2017 and 29 November 2017 are attached at Appendix 1.	To discuss and note

Executive Summary:

The purpose of the Quality Committee, as set out in its Terms of Reference, is to provide detailed scrutiny of the Foundation Trust's arrangements for the management and development of quality and safety in order to provide assurance and, if necessary, raise concerns or make recommendations to the Board of Directors.

The Council of Governors is asked to note the report presented to the Board of Directors on 11 January 2018.

Financial implications:

Regulatory relevance:

Monitor:	

Equality Impact / Implications:	**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

Quality and Safety Committee – 20 December 2017

1. Introduction

The purpose of this paper is to advise the Board of Directors of the key matters discussed and provide a brief summary of agenda items of the Committee which was held on 20 December 2017.

2. Key Matters discussed at the meeting held on 20 December 2017

- A &E Quality Summit Follow Up
- Serious Incidents
- Maternity Improvement Programme
- CQC Compliance
- Review of Sub Committees reporting into the Quality Committee

3. Agenda items

3.1 A&E Deep Dive

A team from A&E presented on progress made since the A & E Quality Summit. The presentation was discussed in great detail by the Committee. Good progress has been made and further work continues.

3.2 Quality Committee Dashboard

The Quality Committee dashboard was discussed

3.3 Information Governance Report

There have been no Level 2 high risk reportable information governance incidents or cyber security breaches in November 2017.

Mandatory information governance training compliance has improved with the delivery of EPR training and is at 88% as at 30 November 2017; below the 95% requirement for March 2018. Plans are in place to acheive the 95% target.

The Information Commissioner's Office Best Practice report has been completed and is ready for final submission to the ICO by 20 December 2017.

3.4 Strategic Staffing Review

A presentation was delivered on the process around the National Strategic Staffing Review. BTHFT's review will be presented to the Board of Directors on 11 January 2018. .

3.5 Serious Incident Report

There have been five new serious incidents reported during November 2017. Three of these were in relation to hospital acquired pressure ulcers. The other incidents related to:

- A patient who had surgery to remove a metastatic renal tumour under general anaesthetic who then arrested immediately post operatively.
- A paediatric safeguarding concern relating to a child who attended the Emergency Department.

Three investigations have been completed and their reports submitted to the Clinical Commissioning Group for approval and closure on the Strategic Information System. These completed investigations related to:

- The failure to provide haemodialysis to a Hepatitis B virus (HBV) positive patient on a designated individual machine.
- The failure of the Temple Bank generator to provide appropriate backup power during a mains power cut.
- The death of a cancer patient who developed sepsis.

3.6 Cancer MDT Process Assurance

Audit Yorkshire completed a review of Cancer Activity Data. The audit confirmed 'significant assurance' that the Foundation Trust has generally robust systems in place to identify record, validate and report cancer wait times associated with patients for whom it provides services. An update on the three key recommendations was provided to the Committee.

3.7 Childrens and Young People's Board Report

In line with the Yorkshire and Humber Strategic Clinical Network, 'Standards Relating to Paediatric General Surgery' and a recommendation from the RCPCH peer review; the Children's and Young People's Board (CYPB) was established as a multi-disciplinary and multi-agency sub-committee of the Foundation Trust's Quality and Safety Committee (QSC).

The report provided an update on:

- Service developments, some of which are in collaboration with GP's and the CCG including ambulatory care, autism and SEND
- Current local changes in children's services, such as the new ward block and local management of specific patient groups and care provision such as stabilisation
- Consideration of service specific annual reports - specifically the Annual Safeguarding Children report.

3.8 Maternity Improvement Programme Action Plan v3

An update was provided on the Maternity Services Improvement Plan and feedback given from the follow up Maternity Summit held on the 13 December 2017. The Committee approved the request to de-escalate the summit process and receive a two monthly update on progress against the action plan.

3.9 Prevent Training Update

The Committee was updated on the work being carried out on re-profiling the trajectory to ensure the target of 85% is met by March 2018.

3.10 Central Alerting System Report

The Committees discussed the CAS report. There are no outstanding NPSAS or MDA alerts.

3.11 CQC Compliance and Assurance

The Committee received an update on CQC inspections, compliance and assurance. The compliance action plan was discussed.

3.12 Governance Review of Sub-Committees of the Quality Committee

The Committee discussed the sub-committees that report into the Quality Committee. Concern was raised about attendance/quoracy of some. Review of this will feed back into a future Committee. The terms of Reference of the sub-committees will be submitted to the next Committee for review.

3.13 Combined Learning Report

The Quarter 2 report, which provides an overview of the learning generated, was discussed by the Committee

3.14 Board Assurance Framework

The Quality Committee is responsible for the following strategic risks in the Board Assurance Framework (BAF).

- **SR1: To provide outstanding care for our patients**
  The Executive Leads are the Chief Nurse and the Medical Director

- **SR4: To be a continually learning organisation**
  The Executive Lead is the Medical Director

The Committee discussed and gained assurance on the management of the risks.

4. Escalation to the Corporate Risk Register

There were no risks to escalate.

5. Recommendation

The Board of Directors is asked to note the above points.

Quality and Safety Committee – 29 November 2017

1. Introduction

The purpose of this paper is to advise the Board of Directors of the key matters discussed and provide a brief summary of agenda items of the Committee which was held on 29 November 2017.

2. Key Matters discussed at the meeting held on 29 November 2017

- Palliative Care Presentation and Annual Report
- Patient Experience
- Safeguarding Training for key BTHFT positions
- Safety Thermometer
- Stoke Services Deep Dive

3. Agenda items

3.1 Quality Committee Dashboard

The Quality Committee dashboard was discussed.

3.2 Information Governance Quality Report

There have been no Level 2 High Risk reportable incidents since the last report.

Mandatory information governance training compliance has improved with the delivery of EPR training and is at 88% as at 31 October 2017; Plans are in place to meet the 95% requirement for March 2018.

3.3 Information Commissioner's Office Visit Update

BTHFT had a consensual visit from the Information Commissioner's Office (ICO) Best Practice team in November 2016.

The ICO made 50 recommendations - 49 accepted or partially accepted and one declined. An Action Plan was developed and executed. Evidence has been compiled to support a response to the ICO in December 2017, as per the plan.

Internal Audit will conduct a final appraisal of the work completed in November/December 2017 before submission of the final status.

3.4 Data Protection Officer Appointment

The General Data Protection Regulation (GDPR) will be adopted into UK law on 25 May 2018. The Trust is required, as a public body, to appoint a Data Protection Officer (DPO).

The Committee approved the recommendation that the role of Data Protection Officer for BTHFT and AHFT is carried out by the Joint Head of Information Governance.

3.5 Palliative Care Annual Report and Presentation

The Palliative Care team presented on End of Life Care at BTHFT and the annual report was noted.

3.6 Serious Incident Report

Three new SIs have been reported since the last report. All three were reportable hospital acquired pressure ulcers.

There were no Never Events reported.

3.7 Clinical Effectiveness Report Q2

The Committee discussed the following elements of the report:

- The management and assurance processes associated with national best practice recommendations (National Institute of Clinical Excellence (NICE) guidance).
- The management and assurance processes associated with the conduct of and assurance related to National Confidential Enquiry into Patient Outcome and Death (NCEPOD) studies.
- The management and the assurance processes associated with the National Clinical Audit and Patient Outcome (NCAPOP) programme and national audits included in the annual Quality Account.
- The management and assurance related to the Trust High Priority local Clinical Audit Programme and the management and assurance related to local clinical audit.
- The management of Trust wide and locally devolved clinical guidance.

3.8 Safer Procedure Update Report

The Committee discussed and approved the approach to be taken in implementing the WHO Surgical Safety Checklist.

3.9 Learning From Deaths Quarterly Update

As part of the national guidance on learning from deaths the Trust is required from quarter three of this financial year 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 update was discussed by the Committee and it was noted that a report will be presented to the January 2018 Board of Directors Meeting.

3.10 Medicines Optimisation

In 2016 the CQC raised significant concerns about the standards of Medicines Safety and Medicines Management within BTHFT. BTHFT submitted a response and action plan to the CQC with specific timescales for actions to be completed, addressing the issues that have been raised by the inspection team. The Committee discussed the Medicines Optimisation paper.

3.11 Review of Training Targets

The Committee discussed and approved the new targets for update/refresher training and noted that core mandatory training remains at 100% compliance.

3.12 Freedom to Speak up Report Q2

The Committee received an update on concerns raised in quarter 2 and any themes that have emerged. The Committee also discussed the published case review, by the National Guardian's Office, of Southport and Ormskirk NHS Trust.

3.13 Infection Control Quarterly Report

2 cases of MRSA bacteraemia occurred in August to October 2017, 1 allocated to the Trust and 1 recurrent case accepted by NHS England as third party. There have been 3 MRSA bacteraemia cases allocated to the Trust since April 2017.

6 cases of C difficile >day 3 of admission were recorded in August to October 2017 giving a maximum number of 11 against a target trajectory of 30.

3.14 Patient Experience Quarterly Report

The Foundation Trust received a total of 115 formal complaints between 1 July and 30 September 2017, which is a 25% decrease of the previous quarter.

The top 3 themes of complaints were appropriateness of treatment, outpatient appointments and staff attitude.

5 cases have been closed by the PHSO in quarter 2, 4 of which were partially upheld and 1 which was not upheld. There have been no new cases but are 6 on-going cases.

234 people contacted PALS in Quarter 2; this is an 18% increase of contacts on the previous quarter.

30% of complaints were closed within agreed timescales.

3.15 Safety Thermometer Update

The Classic safety Thermometer is a measurement tool for improvement that focuses on the four most commonly occurring harms in healthcare: pressure ulcers, falls, urinary tract infections (UTI) (in patients with a catheter) and Venous Thromboembolism (VTE).

There has been deterioration in the percentage of patients receiving care that is free from new harm as measured by Safety Thermometer. This was discussed in detail at the Committee.

3.16 Safeguarding: Children and Adults Update

A midyear update was provided to the Committee for both Adults and Children. The Reports were noted. Discussion occurred around the training provided for key positions within BTHFT.

3.17 Stroke Services Deep Dive

The Stroke Services team presented a deep dive of their services. This was an in-depth presentation with a lot of discussion. A follow up to this is planned for March 2018.

3.18 Board Assurance Framework

The Quality Committee is responsible for the following strategic risks in the Board Assurance Framework (BAF).

- **SR1: To provide outstanding care for our patients**
  The Executive Lead is the Chief Nurse and the Medical Director

- **SR4: To be a continually learning organisation**
  The Executive Lead is the Medical Director

The Committee discussed and gained assurance on the management of the risks.

4. Escalation to the Corporate Risk Register

Safeguarding training for key positions is to be discussed at the next Integrated Governance and Risk Committee.

5. Recommendation

The Board of Directors is asked to note the above points.

Appendix 1

QUALITY COMMITTEE MEETING
MINUTES, ACTIONS & DECISIONS

Date:	Wednesday 25 October 2017	**Time:**	14:00 to 16:00
Venue:	Conference Room, Field House, Bradford Royal Infirmary	**Chair:**	Dr Mohammed Iqbal Non-Executive Director
Present:	**Non-Executive Directors:** - Dr Mohammed Iqbal, Non-Executive Director (MI) - Mr Amjad Pervez, Non-Executive Director (AP) - Ms Selina Ullah, Non-Executive Director (SU) **Executive Directors:** - Ms Cindy Fedell, Director of Informatics (CF) - Mr Matthew Horner, Director of Finance (MH) for agenda items Q.10.17.9 and Q.10.17.10		
In Attendance:	- Dr LeeAnne Elliott, Deputy Medical Director (LAE), representing Dr Bryan Gill, Medical Director (BG) - Mrs Sally Scales, Deputy Chief Nurse (SS), representing Ms Karen Dawber, Chief Nurse (KD) - Mrs Terri Saunderson, Deputy Director of Operations (TS), representing Ms Donna Thompson, Director of Governance and Operations (DT) - Ms Fiona Ritchie, Trust Secretary (FR) - Ms Juliet Kitching, Minute Taker		

No.	Agenda Item	Action
Q.10.17.1	**Apologies for Absence**	
	- Professor Laura Stroud, Non-Executive Director (LS) - Ms Donna Thompson, Director of Governance and Operations (DT) represented by Mrs Terri Saunderson, Deputy Director of Operations (TS) - Dr Bryan Gill, Medical Director (BG), represented by Dr LeeAnne Elliott, Deputy Medical Director - Ms Karen Dawber, Chief Nurse (KD), represented by Mrs Sally Scales, Deputy Chief Nurse.	
Q.10.17.2	**Declaration of Interests**	
	There were no declarations of interest.	
Q.10.17.3	**Minutes and Actions of the Quality and Safety Committee meeting held on 30 August 2017**	
	The minutes of the last meeting were accepted as an accurate record, subject to the addition of Selina Ullah's apologies being noted.	
Q.10.17.4	**Matters Arising**	
	The following items on the action log were closed: Q.7.18.9 (26.07.17) – Quarterly Risk Management Report. Q.8.17.11 (30.08.17) – NHS England Public Health Screening Reports.	
Q.10.17.5	**Quality Committee Terms of Reference** The Terms of Reference for this Board subcommittee were discussed and approved at the Closed Board of Directors meeting held in July 2017. The Terms of Reference were presented for the Committee's information.	

No.	Agenda Item	Action
	The Terms of Reference were noted by the Committee.	
	Board Dashboard	
Q.10.17.6	**Quality Dashboard** CF presented the new Quality Dashboard for the Committee. The new Dashboard integrated with the refreshed Board of Directors' Dashboard is intended to provide a well-rounded, visual view of all aspects of the Foundation Trust (FT) grounded in the new Clinical Strategy. The Dashboard also progresses the use of indicators from reporting on the monthly contractual position to a management tool to enable improvement. The Dashboard is expected to be refined as plans in particular areas progress, and with input from the Committee. The Committee welcomed the new style report. CF explained the dashboard will also be used by the executives and suggested this detailed information is incorporated into the Divisional Performance meetings.	
	Information Governance	
Q.10.17.7 **Q.10.17.8**	**Information Governance (IG) Report** **Senior Information Risk Owner 2017/18 Quarter 2 Update** CF presented the two reports on Information Governance (IG) together. There have been no Level 2 High Risk Reportable IG incidents and no cyber security breaches. Mandatory IG training compliance is expected to improve with the delivery of EPR training, with IG training delivered over the ten weeks preceding EPR Go-Live. The Electronic Patient Record (EPR) went live on the weekend of 23/24 September 2017. The Go-Live saw a refreshed data quality dashboard deployed alongside the EPR to enable data correction, for example, admissions by type, clinic out coming, etc. Key pieces of ongoing work were noted around the IG Toolkit and the Information Commissioner's Office best practice audit recommendation done a year ago. Considerable work with information assets and owners is on-going. An update on the action plan will be provided in December 2017 and at that point the Information Commissioner will decide whether or not to visit the FT in January 2018. Preparedness for the General Data Protection Act coming into force in May 2018 was noted. A baseline audit will be undertaken in the next few weeks to inform preparation planning.	Director of Informatics
Q.10.17.9	**Annual Reported Physical Assaults 2016-17** The paper advised the Committee of the number of reported physical assaults on NHS staff by patients, visitors and the public during the reporting period 1 April 2016 to 31 March 2017. MH highlighted the key points: • NHS Protect is now fully decommissioned with no responsibility, accountability or oversight of security management within the NHS. • Existing security management standards for providers and commissioners remain as the standards are part of the requirements of the current NHS Standard Contract. • The paper compared the last three years of reported physical assaults with a slight decrease in the total number of assaults reported this	

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	year. The number of assaults involving medical factors remains significantly high. • Continued effort has been put into reducing violence and aggression, however, there has been little improvement in the scores, in terms of the percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months. • A number of papers have previously been presented outlining the work required to address the gaps in the management of clinically related challenging behavior and issues discussed at the Integrated Governance and Risk Committee in August 2017. Action plans/training are currently being implemented with a progress report due to be presented at the Information Governance and Risk Committee December meeting. MH to confirm with Karon Snape, Assistant General Manager, Facilities, if benchmarking information is available that would compare the Trust to other local providers.	Director of Finance
Q.10.17.10	**Annual Security Board Report 1 April 2016 to 31 March 2017** MH reported on the paper and advised the Committee of some of the anti-crime and security work undertaken to tackle and prevent crime at the FT during the reporting period 1 April 2016 to 31 March 2017. There is conclusive evidence that crime increases when there are more opportunities to offend, and falls when the number of opportunities are reduced. MH noted the need to continue to work with West Yorkshire Police on the crime of theft. Solutions have been put in place to improve storage to patients and staff property and assets, and the safety of patients and staff. The standards set by NHS Protect, ie strategic governance, prevent and deter, inform and involve and hold to account have continued to be applied. The FT are fully compliant with 25 of over 30 standards and continues to maintain these. A Quarterly Security Steering management group meets to self-assess against the standards.	
Q.10.17.11	**Serious Incidents (SI) Report** LAE noted nine new SI reports were reported during August and September 2017 in the FT, five of which were in relation to pressure ulcers. LAE summarised and discussed the four reported incidents concerning an alleged sexual assault (SI 2017/19296), the death of a cancer patient from sepsis (SI 2017/19750), a successful attempt by an unknown person claiming to be a healthcare professional to enter the FT's wards and access areas where drugs were stored (SI 2017/21347) and an intrauterine death (SI 2017/23948). Regarding the latter case LAE informed the Committee this investigation will be subject to external review. Immediate changes were put in place at the time of each incident and the lessons learned to date were discussed. LAE noted pressure ulcers are monitored carefully through the Patient Safety Sub-Committee.	

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	SU questioned the filling of vacancies in midwifery. SS noted no issues with staffing as compared with general nursing. The number of new midwives commencing in the FT is not particularly different as compared to previous years and the number of experienced midwives leaving has not changed significantly. Five SI investigation reports were completed between August and September 2017 and these were noted by LAE: • SI 2017/9980 – Antenatal Screening Incident. • SI 2017/13891 – Missed Tinzaparin. • SI 2016/11819 – Administration of the incorrect intravenous fluid. LAE noted due to the age of the report this appears in the old style format. However, the case is now fully concluded with the post-mortem stating the issues had no effect on the result and the case will be the subject of a coroner's inquest. • SI 2017/14994 – Failure to respond to a prolonged deterioration. • SI 2017/15632 – Delayed diagnosis of a gynaecology patient with cancer.	
Q.10.17.12	**Venous Thrombo-embolism (VTE) – Assessment and Prevention Action Plan** LAE reported a Trust-wide action plan has been developed to support improvement in the assessment and prevention of VTE in patients. The Committee has previously been made aware of 'precursor incidents' relating to the assessment and prevention of VTE in the FT including, a theme within other reported incidents and coroner's investigations, performance concerns in relation to the completion of the assessment of risk and compliance with NICE guidance. A detailed report will be brought back to the Committee providing assurance in relation to the effectiveness of the action plan at a time and in a format agreed by the Committee. The Committee noted action plan numbers 1.4, 2.3 and 2.4 should state 2018 and not 2017.	Medical Director
Q.10.17.13	**Leadership Walkround – Quarterly Report** LAE provided an update on the progress of the leadership walkrounds from July to September 2017 which included information from the Executive Pairings and the Executive/Non-Executive walkrounds. A summary of the responses including the top three themes identified during this period of team performance, advancing clinical practice and knowledge and the environment were noted and actions taken as required. LAE noted the report identified staff in wards and in departments appreciate the visits and openly engage and discuss issues. The Committee noted if the same Executives/Non-Executives were unable to revisit areas subsequently, it would be useful for a copy of the previous report to be made available. LAE noted information obtained is collated by the Medical Director's Office and discussed at the new Learning and Surveillance hub where themes/trends can be identified.	

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	LAE will feedback to the Medical Director and the Quality Improvement Team.	
Q.10.17.14	**Quality Improvement Update** LAE noted there are a number of quality improvement initiatives in place which aim to improve the care of patients in the FT. A methodology is used which aims to facilitate improvement rather than direct it. The two projects currently underway are aimed at reducing pressure ulcers and improving the recognition of, and response to the deteriorating patient. The project approach has received favourable feedback from those involved and improvements have been seen at this early stage in the programme. A Quality Improvement Strategy is under development ensuring all areas are linked with an aim of launching at the start of April 2018. LAE noted the complex work underway around pressure ulcers, with regards awareness, recognising, reporting, training, the recent staffing changes in the tissue viability team, care plans and ward responsibilities.	
Q.10.17.15	**Quarterly Risk Management Report – Quarter 2** LAE reported: • Incident reporting overall remains consistent. • The incidents that were required to be reported to external agencies were noted. • The learning associated with incidents has been removed from the paper, as requested by the Committee, and will be included quarterly in the Committee's work plan. • A profile of assurance associated with the effectiveness of action planning following an SI was noted. A discussion on cannula care was held. LAE was not aware of any links with performance and finance, and recruitment identifying any impact on quality. The level of consistency as to whether the FT is a safe organisation in comparison with other Trusts was questioned. A national dataset of all reported incidents benchmarks the FT against the number of reports and level of harm.	
Q.10.17.16	**Combined Learning Report – Quarter 1** LAE reported on the Quarter 1 Combined Learning Report providing an overview of the work of and outcomes generated from the organisational learning response system, its precursor 'incident', the learning itself and the modality used to disseminate it across the FT. Due to the implementation of the system within year, the report covers Quarter 1 2017/18. The appendices indicated the types of learning, eg significant concerns, trends and themes. Discussion was held on how this learning contributed to appraisal systems and processes and the work from previous quarterly risk management reports and the learning issues highlighted.	
Q.10.17.17	**Responding and Improving: Maternity Improvement Action Plan** SS discussed the report which provided an overview of the multi-method review undertaken into the quality and governance of the Maternity Service at the FT. The review has been multi-faceted and used many interdependent methodologies including an internal quality summit process and an external review of the service undertaken by The Royal	

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	College of Obstetricians and Gynaecologists which involved staff interviews, focus groups, audit and reviews of incidents. The paper provided a brief contextualisation of the findings of the review to enable a clear focused response, improvement plan, and structure using recognised safety culture domains. The appendix provided a detailed Maternity Improvement Plan drawing recommendations from the outcomes of all elements of the reviews undertaken, identifying key objectives, the actions required and an update on the current progress with the improvement work being undertaken. The action plan was sent through virtually and signed off by Prof J Walker, Non-Executive Director/Chair of the Quality and Safety Committee, in September 2017. A follow-up Maternity Quality Summit is scheduled to take place on Wednesday, 13 December 2017. The Committee questioned how the FT engages with the diverse population within the city, to inform service development. Action 7.2 in the action plan addresses this. An update will be provided at the December meeting on the progress against actions.	Chief Nurse
Q.10.17.18	**Delivering High Quality End of Life Care for People who have a Learning Disability** SS presented the paper outlining the FT's position against the recently published national guidance from the NHS England document: 'Delivering high quality end of life care for people who have a learning disability'. The paper outlines the findings of the review which was undertaken, based on the themes within the framework for palliative care. The document summarised the key points.	
Q.10.17.19	**Summary of National Audit of Dementia – Local Results 2017** SS noted the retrospective audit undertaken which provided an outline of the findings of round 3 (2016-17) of the National Audit of Dementia Care in General Hospitals. The FT's results compare favourably with the national average however, a number of areas require improvement. The recommendations were noted and will be incorporated into the Dementia Steering Group action plan.	
Q.10.17.20	**Nursing Staffing Data Publication Reports – August and September 2017** SS noted the reports provided details of the planned versus actual staffing levels for registered nurses/midwives and care staff for August and September 2017. Robust monitoring remains in place with a daily overview of the staffing in each area to maintain safety. Where areas have identified a risk regarding staffing, mitigation is put in place and monitored, more detail has been included in this paper for further openness and transparency. Activities continue to manage the recruitment of new nurses, retention of existing nurses and efficiency of deployment of the existing and temporary nursing workforce. A paper on nurse recruitment and retention has been presented to the Executive Management Team, which	

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	included a detailed work plan, however, going forward this will be discussed in detail at the Workforce Committee. September fill rates are slightly improved from August both on registered nurses at BRI and SLH and registered nurses, days and nights. Retention rates identify the position compared to other Trusts where the FT is average. Retention rates for healthcare support workers were noted to be slightly below the national average. SS noted a module called SafeCare, is being implemented as part of the eRoster system, which will improve reporting of staff present on each shift, along with the acuity of patients, to support decision making in relation to provision of safe staffing.	
Q.10.17.21	**Integrated Quality and Performance Dashboard: Readmission within 30 days (Bo.9.17.8)** TS provided an update on a query raised about the increase in admission rates, as raised at the last meeting. The effectiveness team are undertaking an investigation into admission rates, to understand the causes and the trends. A report will be provided to the Clinical Audit and Effectiveness Committee and results will be reported through the dashboard.	
Q.10.17.22	**ProgRESS (PROGrammed Reviews of Effectiveness, Safety and Sensitivity) – 100 Day Report** TS noted ProgRESS is a key organisational method for enquiry and assurance providing an update on activity around the ProgRESS work plan, a programme of internal and external reviews and supporting FT assurance process with particular reference to Care Quality Commission (CQC) standards. An analysis of the conduct of the programme was noted and a summary of reviews undertaken was provided. TS described the work plan performance, the completed essential programme reviews and the work schedules. Outputs from four reviews completed this year were noted along with timescales for process reviews and submissions.	
Q.10.17.23	**Any Other Business** Q.10.17.23.1 – A paper entitled, 'Sentinel Stroke National Audit Programme (SSNAP) – Mortality Outlier' was tabled by LAE, as a supplement to previous information circulated to the Board on the issues around the SSNAP audit due for publication in the near future. The FT had been identified as an outlier for mortality in relation to stroke for the year 2016/17. Initial investigations have taken place and steps are underway to review, with a Quality Summit arranged to look at the overall care within the stroke service. An issue that has already been identified that may have impacted on the national audit, is the move of the hyperacute stroke service from Airedale to Bradford which increased by one-third the number of stroke cases. Data quality issues have been identified relating to the data submitted to the SSNAP audit programme. HED data is reviewed regularly by the FT	

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	and an update will be provided at the November Quality Committee along with a deep dive into the stroke service.	
Q.10.17.24	**Matters to escalate to the Corporate Risk Register** There were no matters to escalate to the Corporate Risk Register.	
Q.10.17.25	**Matters to escalate to the Board of Directors** • New Committee Dashboard • Security and Physical Assaults • Serious Incidents • VTE • Risk Management • Maternity Improvement Action Plan	
Q.10.17.26	**Items for Corporate Communication** There were no items for Corporate Communication.	
Q.10.17.27	**Date and time of next meeting** 2 pm to 4 pm, Wednesday 29 November 2017 Conference Room, Field House, BRI.	

Bradford Teaching Hospitals NHS Foundation Trust

BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST
ACTIONS FROM QUALITY COMMITTEE – 25 October 2017

Date of Meeting	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
30.08.17	Q.8.17.15	**Serious Incident (SI)/Never Event Report** SI 2017/1742 (power failure) – DT agreed to seek information from Estates as to whether systems need to be reviewed.	Director of Operations and Governance	29/11/17	25/10/17: TS confirmed DT has undertaken the timeline with Estates, to understand the checks were made and conducted and there will be a report presented to the next Quality Committee.
25.10.17	Q.10.17.9	**Annual Reported Physical Assaults 2016-17** MH to confirm with Karon Snape, Assistant General Manager, Facilities, if benchmarking information is available that would compare the Trust to other local providers.	Director of Finance	29/11/17	At the moment there is no comparative benchmarking, however, a number of Organisations including BTHFT have affiliated with the National Association of Healthcare Security (NAHS). This is a non-profit making professional organisation working to continually improve security in healthcare through training and the exchange of information. Information sharing is on the agenda, but not yet finalized. Item concluded
25.10.17	Q.10.17.21	**Integrated Quality and Performance Dashboard** - The effectiveness team are undertaking an investigation into admission rates, to understand the causes and the trends. A report will be provided to the Clinical Audit and Effectiveness Committee and results will be reported through the dashboard.	Director of Operations and Governance	29/11/17	

Date of Meeting	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
26/07/2017	Q.7.17.5	**Serious Incident (SI)/Never Events Report** There may be significant variance between MDTs and therefore assurance was required that processes had include safeguards to ensure that patients were not lost to treatment. Report to be produced for the November Committee meeting.	Medical Director	20/12/2017	Deferred from November 2017 to December 2017
25.10.17	Q.10.17.7/8	**Information Governance Report** **Senior Information Risk Owner 2017/18 Quarter 2 Update** An update on the action plan will be provided in December 2017 and at that point the Information Commissioner will decide whether or not to visit the FT in January 2018.	Director of Informatics	20/12/17	
25.10.17	Q.10.17.17	**Responding and Improving: Maternity Improvement Action Plan –** The Committee questioned how the FT engages with the diverse population within the city, to inform service development. Action 7.2 in the action plan addresses this. An update will be provided at the December meeting on the progress against actions.	Chief Nurse	20/12/17	
25.10.17	Q.10.17.12	**Venous Thrombo-embolism – Assessment and Prevention Action Plan** – A detailed report will be brought back to the Committee providing assurance in relation to the effectiveness of the action plan at a time and in a format agreed by the Committee.	Medical Director	31/01/18	

QUALITY COMMITTEE MEETING
MINUTES, ACTIONS & DECISIONS

Date:	Wednesday 29 November 2017	**Time:**	14:00 to 16:00
Venue:	Conference Room, Field House, Bradford Royal Infirmary	**Chair:**	Professor Laura Stroud Non-Executive Director
Present:	**Non-Executive Directors:** - Professor Laura Stroud, Non-Executive Director (LS) - Mr Amjad Pervez, Non-Executive Director (AP) - Ms Selina Ullah, Non-Executive Director (SU) **Executive Directors:** - Dr Bryan Gill, Medical Director (BG) - Ms Cindy Fedell, Director of Informatics (CF) - Ms Donna Thompson, Director of Governance and Operations (DT)		
In Attendance:	- Sally Scales, Deputy Chief Nurse (SS), representing Ms Karen Dawber, Chief Nurse (KD) - Dr Andrew Daley (AD), Consultant in Palliative Care, and Elizabeth Price (EP), Clinical Nurse Specialists, Palliative Care for agenda item Q.11.17.9 - Dr Stuart Maguire (SM), Consultant Stroke Medicine and Ann Bannister (AB), Directorate Manager Acute Medicine for agenda item Q.11.17.23 - Ms Fiona Ritchie, Trust Secretary (FR) - Ms Juliet Kitching, Minute Taker		
Observer:	- Dr Mark Greasley, Final Year Trainee (Observer)		

No.	Agenda Item	Action
Q.11.17.1	**Apologies for Absence** - Karen Dawber, Chief Nurse, represented by Sally Scales, Deputy Chief Nurse - Dr Mohammed Iqbal, Non-Executive Director (MI)	
Q.11.17.2	**Declaration of Interests** There were no declarations of interest.	
Q.11.17.3	**Minutes and Actions of the Quality Committee meeting held on 25 October 2017** The minutes of the last meeting were accepted as an accurate record.	
Q.11.17.4	**Matters Arising** The following items on the action log were closed: Q.10.17.9 (25.10.17) – Annual Reported Physical Assaults 2016-17. Q.10.17.21 (25.10.17) – Integrated Quality and Performance Dashboard.	
	Board Dashboard	
Q.11.17.5	**Quality Committee Dashboard** LS commented on this positive and informative document presented to the Committee which has been developed following the refreshed Dashboard for the Board of Directors. CF noted the indicators for the Quality Committee have been extracted	

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	from the Board Dashboard. The Dashboard will be further developed and adjusted over time.	
	Information Governance	
Q.11.17.6	**Information Governance (IG) Report** CF noted there have been no Level 2 high risk reportable IG incidents. Mandatory IG training compliance was at 88% at 31 October 2017. The team is rechecking the data to ensure it is correct. Data Quality is focussed on embedding the correct use of the Electronic Patient Record (EPR). The position is improving since issuing this report as the teams work through a detailed action plan to reduce errors and correct the backlog.	
Q.11.17.7	**Information Commissioner's Office Visit Update** CF reminded the Committee of the consensual visit from the Information Commissioner's Office (ICO) Best Practice Team in November 2016 in which the Trust selected some areas where they believed there was existing good practice and some areas where they believed improvement was needed in order to learn from the visit. The ICO made 50 recommendations with 49 accepted or partially accepted and one declined. An action plan has been developed. The detailed action plan status has been reviewed by the IG Sub-Committee and the Executive Management Team. Internal audit will conduct a final review of the status in November/December 2017, which will then be submitted to the ICO. The Quality Committee noted the work undertaken to meet the recommendations from the ICO and supported the submission to the ICO.	
Q.11.17.8	**Data Protection Officer Appointment** CF discussed the General Data Protection Regulation, which will be adopted into UK law in May 2018. The Trust is required, as a public body, to appoint a Data Protection Officer (DPO). This post can be adopted by an existing member of staff as long as this does not give rise to a conflict of interest and the professional duties of the employee must be compatible with the duties of the DPO. The DPO must have knowledge of Information Technology systems and data flows and be able to voice independently any concerns without repercussions. The Information Governance Sub-Committee has reviewed the requirements and is recommending the Joint Head of Information Governance role, appointed by both BTHFT and Airedale Hospital Foundation Trust, undertake the responsibilities and be appointed DPO. She noted that the dual reporting structure ensures no potential repercussion to voicing any concerns. The Committee approved the recommendation of the Information Governance Sub-Committee for the DPO role be included in the Joint Head of Information Governance role.	
	Quality	
Q.11.17.9	**Palliative Care Team Annual Report** Dr Andrew Daley (AD), Consultant in Palliative Care and Elizabeth Price (EP), Clinical Nurse Specialist, Palliative Care were welcomed to the	

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	meeting and presented the following.  Q.11.17.9 - End of Life Care presentatio The achievements by the End of Life Care Team in BTHFT were noted. A total of 870 patients have been seen by the Hospital Palliative Care Team with a 21% increase in referrals over the past two years. 48% of patients have a non-cancer diagnosis. Of note the team sees 30% of all hospital deaths, an increase of 11% over the last two years with no increase in resource to the team. SU noted information on the cost of people dying in hospital would be of interest to Commissioners. To date this had not been quantified. LS thanked AD and EP for their clear and impressive presentation. Compassionate care is being delivered. The key challenge referred to the securing of funding. Progress made over the last two years and the assurances were noted. BG suggested that due to Airedale and Bradford coming together in a formal collaboration, there is an opportunity to think about related services across the two Trusts and to explore these routes further in order to deliver the service as a whole. Several suggestions were made to the team by Committee members about potential sources of external funding. The Committee noted the Palliative Care Team Annual Report July 2016 to July 2017.	
Q.11.17.10	**Serious Incidents (SI)/Never Event Report** BG noted three new SI reports during October, all of which were in relation to pressure ulcers. Pressure ulcers and falls come under a different categorisation around the way these are investigated, however, are reported under the same national standards. Advice had been sought from the Clinical Commissioning Group (CCG) regarding the level of investigation for the intrauterine death declared in September 2017. Following discussion a level three investigation has now commenced involving an external investigator. Immediate actions required and learning has been identified, as described in the report to the Committee received in October, and this is being managed by the Division. A formal request has been made and agreed by the CCG for an extension to allow the investigators the 60 working days in which to complete and submit the report. The CCG has raised concern over the number of SI investigations related to pressure ulcers that are exceeding the timescales defined in the National Framework. The Chief Nurse's Office is addressing the concern and the position should be rectified by the end of December 2017.	

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	There have been no SI investigation reports requiring sign-off by the Foundation Trust (FT) for submission to the CCG for review in October 2017. BG noted a dedicated piece of work has commenced in the FT this week using the Institute for Healthcare Improvement (IHI) breakthrough series and collaborative approach with regards pressure ulcers. A similar approach to reducing harm from falls has recently started, targeting the wards with the highest number of falls.	
Q.10.17.11	**Clinical Effectiveness Report Q2 (NICE and Audit)** DT presented the report describing the FT's position in relation to the implementation of National Institute of Clinical Excellence (NICE) guidance, national and local clinical audit, national enquiries and the development and management of clinical guidance. The key issues were reported: • There is a continual programme of NICE guidance. There are elements where the FT is not fully compliant with these guidelines, however, these are constantly monitored carefully and plans are in place to progress guidance. Any risks associated with non-compliance are escalated. • There are three outstanding National Confidential Enquiries into Patient Outcome and Death (NCEPOD) – These are unlikely to be significant risks as the FT is compliant in these areas. • Participation in the National Clinical Audit Programme where some audits are mandated and others not. DT suggested the Committee may wish to consider deep dives into other areas explored under the National Clinical Audit Programme, for example external data reporting, however, a review group is now in place to review data before this leaves the organisation ensuring a fully robust process. • Following the last Care Quality Commission (CQC) inspection, a number of clinical guidelines were noted to be out of date in the FT. Much work has been undertaken over the last twelve months to rectify the position. • The National Audit Benchmarking Initiative will be launched in Quarter 3 2017/18. LS raised the issue of the responsibility for quality of care and guidelines and processes to ensure compliance. Quality is measured at specialty level with validation through national audits. These processes are used by clinicians to drive improvement. The Committee noted local clinical audit should be linked to strategy for quality improvement providing assurance around processes in place. A personal score card for employees was discussed to feedback through the appraisal process.	
Q.11.17.12	**Safer Procedure Update Report** BG reported the paper provided an update of the current work completed in relation to National Safety Standards for Invasive Procedures (NatSSIP) and the World Health Organisation (WHO) Surgical Safety	

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	checklist with BTHFT, and evidence provided of improvements to date. Work has been ongoing within the organisation to implement the WHO Surgical Safety Checklist since the alert was published, there are still improvements to be made which incorporate both the guidance in the NPSA alert and the NATSSIPs guidance. BG described the work undertaken in theatres which has led to a changed environment and culture. This work will be rolled out into other areas where the safety checklist process applies. The Bradford Safety Standards for Invasive Procedures (BradSIPP) Implementation Group has revised and approved the Safe Procedures Policy: BradSIPP to ensure compliance with NatSIPP and to set the standard for Bradford. BG noted the successful bid for the new Patient Safety Translation Research Centre will look at determinants of success and how these can be replicated.	
Q.11.17.13	**Learning from Deaths Quarterly Update** BG noted the FT is required from quarter three of this financial year to publish information on deaths, reviews and investigations via a quarterly agenda item and paper to its public Board meeting. The paper will be submitted to the January Board of Directors containing the information recommended in the national guidance. BG reported two mortality rates, the Summary Hospital Mortality Indicator at 96 (as expected), and the Hospital Standardised Mortality Ratio reported as 86 (lower than expected). Mortality rates continue to be better than expected. Review processes have been introduced. Standards are being met, however, the challenge for the organisation at some point is to report avoidable mortality. This subject continues to be debated. BG highlighted Appendix 2, the learning from deaths information, identifying the very high level of quality of care.	
Q.11.17.14	**Medicine Optimisation** BG noted in 2016 the Care Quality Commission (CQC) raised significant concerns about the standards of Medicines Safety and Medicines Management in the FT. A response and action plan has been submitted to the CQC with timescales, addressing the issues that have been raised by the inspection team. The actions taken to date demonstrate improvements in medicines reconciliation rates, medicines storage and consistency of the auditing and monitoring of fridge temperatures. BG applauded the work of the wards and the Pharmacy Service. Business cases for automated dispensing cabinets and the Pharmacy Stock Management Service are working their way through the business case approval process. The report was presented to the Quality Committee for assurance and to	

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	identify the progress made. EPR has aided the process and results compare favourably to the national picture. The Committee referenced the workforce model for a clinical ward and were assured with the actions provided within the report.	
Q.11.17.15	**Review of Compliance Target for Core Mandatory and High Priority Clinical Safety Training** BG noted core mandatory training has always had a compliance target of 100%. The level makes no distinction between whether staff have just joined the FT or have been through regular refresher/update training. Review of local Trusts demonstrates that BTHFT's standard is higher than other acute providers. There is no national standard for mandatory training rates except Information Governance. Core mandatory training for new starters will remain at 100% and is delivered at induction. Future compliance targets for update/refresher training for Core Mandatory Training will be set at 85% with the exception of Information Governance which will remain at 95% as per the national requirement. High priority clinical training rates will remain at 75%. Key skills and knowledge are kept under continual review at specialty level. Training levels are monitored through the Electronic Staff Record and the Education Service maintains provision of monthly compliance reports to the Divisional and Directorate teams and the Performance Committee to facilitate management of compliance by the teams. The Committee approved the proposal.	
Q.11.17.16	**Freedom to Speak Up (FTSU) Quarterly 2 report** SS reminded the Committee that KD is the FTSU Guardian for the organisation and updated the Committee on the FT's FTSU campaign, including the progress to date of the FTSU focus group and the number of FTSU concerns raised in Quarter 2, identifying the concerns and themes. The data submitted from the FT for Quarter 2 to the National Guardian's Office, the published case review completed at Southport and Ormskirk Trust and the National Guardian's Office Annual report were also noted. SS advised there are a number of FTSU Associate Guardians in the FT and the Staff Side Partnership Lead is one of those Guardians.	
Q.11.17.17	**Infection Prevention and Control Report – August to October 2017** SS reported two cases of MRSA bacteraemia occurred between August and October 2017, one being allocated to the FT and one a recurrent case accepted by NHS England as third party. SS advised there have been three MRSA bacteraemia cases allocated to the FT since April 2017. Six cases of *C.difficile* greater than day 3 of admission were recorded	

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	between August and October 2017, giving a maximum number of 11 against a target trajectory of 30. SS noted there is an overall health economy target of reducing healthcare related Gram negative bacteraemia cases by 50% by 2022. The infection prevention and control team are working with the CCG and Public Health England to address this, and have been invited to join a performance improvement network event being held by NHS Improvement in December 2017. The report was noted.	
Q.11.17.18	**Patient Experience Report – Quarter 2** SS apologised for the discrepancies submitted in the original paper which had been rectified and were highlighted in yellow on the updated report submitted. SS reported the FT has received a total of 115 formal complaints between 1 July and 30 September 2017, a decrease of 25% on the previous quarter. The top three themes of complaints were appropriateness of treatment, outpatient appointments and staff attitude. Five cases have been closed by the Parliamentary Health Service Ombudsman in Quarter 2, four of which were partially upheld and one which was not upheld. There have been no new cases in this period but six cases are on-going. The paper noted an overview of feedback posted on the NHS Choices website. It was noted 96% of patients completing the Friends and Family Test 'would recommend' the care they received. Accident and Emergency continues as a challenge for responses to the Family and Friends Test and a bid has been submitted to house a kiosk in the Department to assist in improving responses. The National Cancer Patient Experience Survey Summary 2016 and the National Children and Young People's Inpatient and Day Case Survey 2016, attached as Appendices have identified a number of areas where improvements can be made and these are being monitored through the Patient Services Committee. The internal audit report into complaint handling was noted. A query was raised about some of the themes, ie the appropriateness of treatment and how this was determined. This was noted to be the qualitative judgement from the patients. SS noted the report is considered at the Patient First Committee with KD overseeing responses to all complaints and any medical staffing issues being picked up by BG. SS noted much work has been undertaken with complaint investigations and responses to improve the quality. BG described approximately 250,000 patient contacts every quarter and 11 cases of discontent.	
Q.11.17.19	**Safety Thermometer Update – November 2017** The paper was presented by SS providing an update and assurance on the classic safety thermometer. This is a measurement tool for improvement on the four most commonly occurring harms in heathcare, these being pressure ulcers, falls, urinary tract infections and venous thromboembolism. Separate groups have been set up to look at these individual areas. The report highlighted the FT's performance and this	

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	was discussed by the Committee. The safety thermometer data is not currently validated prior to being reported externally on the national site, but changes have been put in place to ensure this is in place from December. BG noted improvements are actioned via teams through the IHI Breakthrough series collaborative. The Committee was assured.	
Q.11.17.20	**Safeguarding Children Update 2017-2018** SS discussed the Safeguarding Children Update 2017-18 providing a midyear update on the work of the Safeguarding Children's Team. BTHFT currently scores as being 98% compliant with the section 11 audit, with work only required around Standard 9 which is the 'Early Help Offer'. The latter, however, is out with the FT's control as this falls within the Local Authority remit. The Committee noted the Joint Targeted Area Inspection action plan is now complete and the overall Trust compliance for safeguarding children is 94%. SS noted the training for compliance around core mandatory requirements. 77% compliance has been attained for Level 3 staff (specialist staff and ward managers), however, numbers are small. The paper was noted and assurance gained.	
Q.11.17.21	**Safeguarding Adults Mid-Year Update 2017-2018** SS advised the paper provided a mid-year update on the work of the Safeguarding Adults Team. Following an overall review of safeguarding training and reallocation of the required level by staff group, more staff now require level 2 and level 3 training which has consequently resulted in a reduction in the compliance figures. A number of training programmes are in place to ensure training is delivered. Robust plans are in place to increase the numbers of personnel who are trained in 'prevent training'. Focussed action is being undertaken in the Accident and Emergency Department by the Safeguarding Adults Team to raise awareness around the identification of domestic abuse in order that advice and signposting to support services can be provided when required. An audit has shown this training to date has had a positive impact. Concern was expressed regarding the compliance with the requirements for WRAP (Workshop to Raise Awareness of Prevent) training. There has been lack of clarity over which staff needed to undertake this training, but this has now been clarified. Trust staff have undertaken train the trainer sessions, and dates for 2018 planned, however, current compliance is only 31%. SS agreed a plan and trajectory will be submitted to the December meeting and the item will be escalated to the Corporate Risk Register.	Chief Nurse

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Q.11.17.22	**Stroke Deep Dive** Dr Stuart Maguire, Consultant Stroke Medicine, and Ann Bannister, Directorate Manager Acute Medicine were welcomed to the meeting to present an update on the Stroke Services since the April 2017 presentation to the Committee. Q.11.17.22 - Stroke Presentation.pdf Sentinel Stroke National Audit Programme (SSNAP) results in April 2017 were poor and in October 2017 the FT received an alert informing that they had been identified as an outlier by The Royal College of Physicians for mortality. Much improvement work has been undertaken in a short space of time. The FT had no indication from the HES data or in-house mortality review that the FT was an outlier. SM noted SSNAP data is the way the FT is measured against other hospitals as to how stroke services are functioning. Further collaborative work is required between Bradford and Airedale and Bradford and Calderdale and Huddersfield. SM highlighted the following: • Mortality Alert. • Hospital Episode Statistics (HES) data. • Two main workstreams – Improvements delivered to the service from April 2017 and the improvements in the quality of data collection ensuring SSNAP results give a meaningful representation of the service. • Stroke Responder Service – Reintroduced and now delivered. The challenge is now to pick up more strokes on downstream wards. • Service Improvements – Stroke responders, ward mergers, the new stroke unit and the major positive operational effect on the service were noted. Emergency Care Standards and Bradford's collaboration with Airedale and Calderdale and Huddersfield. • The Early Supported Discharge Team. • SSNAP Data collection – Issues had been resolved following the introduction of EPR. Paper records are, however, where necessary still being consulted. A weekly validation meeting is now held with the stroke team. • Action plan – A planned SSNAP team visit, review model of the stroke responder service model, early supported discharge, emergency care standards. • Projected SSNAP data – October 2017 to January 2018, January 2018 to April 2018, ensuring meaningful representation of the service as this will be how the FT is judged regionally and nationally. A Quality Summit has been held and a follow-up meeting organised. Hospital data from August is currently being validated for submission in January 2018. Data for all patients will be updated from April 2017 to inform the annual mortality reporting due in Autumn 2018.	

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	Following participation by the FT in local and regional events, the Committee noted with support from within the organisation the service should flourish. SS noted the need to ensure staffing requirements are fed into the annual strategic staffing review. AB will speak to S Freeman, Head of Nursing, Division of Medicine and Integrated Care. LS thanked the team for their concise presentation and noted a clear desire to improve the service. The challenges faced were accepted and work is now underway with regards cultural aspects, developments and collaboration. The Stroke Service will next present to the Quality Committee in March 2018.	Medical Director
Q.11.17.23 **Q.11.17.24**	**Risk Appetite** **Board Assurance Framework** DT noted this was the first time the Board Assurance Framework had been considered in this format at this Committee. The Committee oversees the following two strategic objectives: SR1 – To provide outstanding care for our patients and SR4 – To be a continually learning organisation. With regard to SR1, DT noted some elements of positive assurance but also some elements of negative assurance in terms of providing outstanding care. Assurance level – Amber, minimal risk. Risk appetite was deemed as minimal by the Committee. SR4 – Assurance level not proposed. Risk appetite – Appropriate. With regards to SR1, an overall delivery plan has been developed for the FT and DT agreed to share this with the Committee. The Committee were content with the ratings.	Director of Governance and Operations
Q.11.17.25	**Any Other Business** There was no other business.	
Q.11.17.26	**Matters to Escalate to the Corporate Risk Register** Level 2/3 Safeguarding Training.	Chief Nurse
Q.11.17.27	**Matters to Escalate to the Board of Directors** • Palliative Care Presentation and Annual Report • Patient Experience • Safeguarding Training for key BTHFT positions • Safety Thermometer • Stoke Services Deep Dive	
Q.11.17.28	**Items for Corporate Communication** • EDs to inform John Holden, Director of Strategy and Transformation, of the good news stories.	
Q.11.17.29	**Date and time of next meeting** 2 pm to 4 pm, Wednesday 20 December 2017 Conference Room, Field House, BRI.	

Bradford Teaching Hospitals NHS Foundation Trust

BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST
ACTIONS FROM QUALITY COMMITTEE – 29 November 2017

Date of Meeting	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
30.08.17	Q.8.17.15	**Serious Incident (SI)/Never Event Report** SI 2017/1742 (power failure) – DT agreed to seek information from Estates as to whether systems need to be reviewed.	Director of Operations and Governance	20/12/17	25/10/17: TS confirmed DT has undertaken the timeline with Estates, to understand the checks were made and conducted and there will be a report presented to the next Quality Committee. 29/11/17: DT assured the Committee immediate actions have been taken following review of Estate systems and where necessary changes implemented. A report will be submitted to the December meeting.
26/07/2017	Q.7.17.5	**Serious Incident (SI)/Never Events Report** There may be significant variance between MDTs and therefore assurance was required that processes had include safeguards to ensure that patients were not lost to treatment. Report to be produced for the November Committee meeting.	Medical Director	20/12/2017	Deferred from November 2017 to December 2017.
25.10.17	Q.10.17.7/8	**Information Governance Report** **Senior Information Risk Owner 2017/18 Quarter 2 Update** An update on the action plan will be provided in December 2017 and at that point the Information Commissioner will decide whether or not to visit the FT in January 2018.	Director of Informatics	20/12/17	

Date of Meeting	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
25.10.17	Q.10.17.17	**Responding and Improving: Maternity Improvement Action Plan –** The Committee questioned how the FT engages with the diverse population within the city, to inform service development. Action 7.2 in the action plan addresses this. An update will be provided at the December meeting on the progress against actions.	Chief Nurse	20/12/17	
29.11.17	Q.11.17.21	**Safeguarding Adults Mid-Year Update 2017-18** – Trust staff have undertaken train the trainer sessions, and dates for 2018 planned, however, current compliance is only 31%. SS agreed a plan and trajectory will be submitted to the December meeting.	Chief Nurse	20/12/17	
29.11.17	Q.11.17.24	**Board Assurance Framework** – SR4 – An overall delivery plan has been developed for the FT and DT agreed to share this with the Committee.	Director of Governance and Operations	20/12/17	
29.11.17	Q.11.17.26	**Matters to Escalate to the Corporate Risk Register** Level 2/3 Safeguarding training	Chief Nurse	20/12/17	
25.10.17	Q.10.17.12	**Venous Thrombo-embolism – Assessment and Prevention Action Plan** – A detailed report will be brought back to the Committee providing assurance in relation to the effectiveness of the action plan at a time and in a format agreed by the Committee.	Medical Director	31/01/18	
29.11.17	Q.11.17.22	**Stroke Deep Dive** – The Stroke Service will next present to the Quality Committee in March 2018.	Medical Director	28/03/18	