

<b>Meeting Title</b>	<b>Board of Directors</b>		
<b>Date</b>	<b>13.9.18</b>	<b>Agenda item</b>	<b>Bo.9.18.34</b>

## CONFIRMED MINUTES OF QUALITY COMMITTEE MEETINGS 27 JUNE & 25 JULY 2018

Presented by	Chair of the Quality Committee		
Author	N/A		
Lead Director	Karen Dawber, Chief Nurse and Bryan Gill, Medical Director		
Purpose of the paper	To present the Board with the confirmed minutes of the Quality Committee 27 June and 25 July 2018		
Key control	<p>This paper provides the minutes of the meeting of a Board Committee that assures the strategic objectives to:</p> <ul style="list-style-type: none"><li>- Provide outstanding care for our patients</li><li>- Be a continually learning organisation</li></ul>		
Action required	To receive		
Previously discussed at/ informed by	Quality Committee		
Previously approved at:	Committee/Group	Date	
	Quality Committee	25 July 2018 & 29 August 2018	
Recommendation			
The Board of Directors is requested to note the content of the minutes and the escalations and actions identified			

**QUALITY COMMITTEE  
MINUTES, ACTIONS & DECISIONS**

<b>Date:</b>	Wednesday 27 June 2018	<b>Time:</b>	14:00-17:00
<b>Venue:</b>	Conference Room, Field House, Bradford Royal Infirmary	<b>Chair:</b>	Professor Laura Stroud Non-Executive Director
<b>Present:</b>	<p><b>Non-Executive Directors:</b></p> <ul style="list-style-type: none"> <li>- Professor Laura Stroud, Non-Executive Director (LS)</li> <li>- Ms Selina Ullah, Non-Executive Director (SU)</li> </ul> <p><b>Executive Directors:</b></p> <ul style="list-style-type: none"> <li>- Dr Tanya Claridge, Director of Governance and Corporate Affairs (TC) left the meeting at 3.30 pm</li> <li>- Dr Bryan Gill, Medical Director (BG)</li> <li>- Ms Cindy Fedell, Director of Informatics (CF) left the meeting at 4.15 pm</li> <li>- Ms Karen Dawber, Chief Nurse (KD)</li> </ul>		
<b>In Attendance:</b>	<ul style="list-style-type: none"> <li>- Mr Paul Featherstone, Director of Estates and Facilities (PF) and Ms Karon Snape, Assistant Director of Facilities (KS) in attendance for Q.6.18.5 and Q.6.18.6</li> <li>- Mrs Sue Franklin, Associate Chief Nurse for Quality Improvement (SF) in attendance for Q.6.18.8</li> <li>- Mr Paul Pallister, Trust Secretary (PP)</li> <li>- Ms Juliet Kitching, PA (Minutes)</li> </ul>		

No.	Agenda Item	Action
<b>Q.6.18.1</b>	<p><b>Apologies for Absence</b></p> <ul style="list-style-type: none"> <li>- Mr Jon Prashar, Non-Executive Director (JP)</li> <li>- Mr Amjad Pervez, Non-Executive Director (AP)</li> </ul>	
<b>Q.6.18.2</b>	<p><b>Declaration of Interests</b></p> <p>There were no declarations of interest.</p>	
<b>Q.6.18.3</b>	<p><b>Minutes and Actions of the Quality Committee meeting held on 30 May 2018</b></p> <p>The minutes were accepted as a correct record.</p>	
<b>Q.6.18.4</b>	<p><b>Matters Arising</b></p> <p>The Committee noted that the following actions had been concluded:</p> <p>Q.3.18.5 (28.03.18) – NICE Guidance on Rheumatoid Arthritis: Compliance and Issues.</p> <p>Q.4.18.13 (25.04.18) – High Priority Audit Programme 2018/19.</p> <p>Q.4.18.5 (30.05.18) – Quality Committee Work plan 2018-19.</p> <p>Q.5.18.8 (30.05.18) – Quality Oversight System.</p> <p>Q.5.18.6 (30.05.18) – Focus On: The Maternity Improvement Programme.</p>	
<b>Q.6.18.5</b>	<p><b>Annual Security Report 2017-18</b></p> <p>KS discussed the report which feeds into the Annual Board report. NHS Protect was decommissioned in March 2017 and security management arrangements are now the responsibility of the Board of Directors with external</p>	

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	<p>scrutiny from commissioners. The standards used for providers for the 2016 security and management paper had been used to self-assess for 2017/18 and the same is proposed for 2018/19. The paper outlined how the Foundation Trust (FT) met the requirements under the service conditions 24 of the NHS Standard Contract, enabling a summary to be produced of the anticrime work conducted over the previous 12 months.</p> <p>The report demonstrated the work and addressed the current crime trends requiring continued focus during 2018/19, eg assault, theft, public order, threatening behaviour, violence and aggression, drugs, criminal damage, hate crime and domestic violence. The Committee discussed:</p> <ul style="list-style-type: none"> <li>• Violence and aggression around ward visiting.</li> <li>• Ward security, the numbers of ward visitors and the prompt discharge of patients.</li> <li>• Drug users and trafficking issues currently under discussion with the Police.</li> <li>• Theft of both patient and staff property.</li> <li>• Improved CCTV in an attempt to ensure prosecutions.</li> <li>• Successful infant abduction prevention.</li> <li>• Proposals to take a lead with the Bradford Hate Crime Partnership.</li> <li>• Changes to the Datix Information System.</li> <li>• Conflict resolution training.</li> </ul> <p>The Committee noted the report and the quality of work ongoing from a reassurance perspective and the balance required to keep patients and staff safe, the work described by KS in relation to the different areas from a staff and wellbeing perspective, ensuring vulnerable areas are safe and reports to public health and other agencies.</p>	
Q.6.18.6	<p><b>Annual Reported Physical Assaults 2017-18</b></p> <p>KS reported since the decommissioning of the security arm of NHS Protect, NHS Standard Contract continues to dictate submission of statics on an annual basis. In the absence of NHS Protect, who used to nationally benchmark these statistics, NHS England and NHS Improvement are working in collaboration to assess the requirements of tackling violence and aggression in the NHS. In June the FT's annual physical assault report was submitted. The following were highlighted:</p> <ul style="list-style-type: none"> <li>• The slight increase in the number of assaults in the year by 18 (132 physical assaults versus 124).</li> <li>• The paper compares statistics over the last four years. Intentional assaults are significantly reduced and well managed. The largest group where assaults have resulted are where clinical factors play a part. The prevention and management of clinically related challenging behaviour remains a key area of focus.</li> <li>• A working group meets looking at outstanding training requirements, including conflict resolution and intervention theories.</li> <li>• The FT is currently non-compliant with one of the security standards for providers, ie the management of violence and aggression where there is a need to implement Department of Health initiatives around this group of patients. Discussions have taken place and work in this area is underway.</li> <li>• Increased patrols by the Security Team visiting high reporting areas to ensure adequate management plans to deter violence and aggression. Security engage with the wards around escalating behaviour in order</li> </ul>	


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	<p>behaviour plans can be put in place.</p> <ul style="list-style-type: none"> <li>• PCSOs meet with senior nursing staff to ensure adequate safety arrangements are in place over the weekend periods.</li> <li>• Markers are added to the Electronic Patient Record (EPR) if patients are identified as a risk and a management plan created. KS noted the majority are of low level injury causing incidents and are reported in the Quarterly Risk Management report. These will be triangulated in the appendix for next year's report.</li> </ul> <p>The following actions were noted:</p> <ul style="list-style-type: none"> <li>• Management and handling support for staff of clinically related challenging behaviour to be subdivided, eg mental health, identified incapacity, iatrogenic and self-induced. A subgroup is currently looking at themes of assault, eg drug induced, dementia and safeguarding in order specific training requirements can be identified.</li> <li>• Increase in unpredictable and violent behaviour when patients attend Accident and Emergency and on wards under the influence of drugs. These areas of concern are documented in the Annual Board report. Work is to be undertaken with regards to illicit substances.</li> <li>• Training around restraint techniques, particularly in relation to minors with the Safeguarding team. Security are not trained, however, any restraint was noted to be clinically led with therapeutic holding. The Security Team are, however, trained to deal with adult restraint techniques. Post-incident debriefs looking at recognised warning signs are undertaken.</li> <li>• Benchmarking against other Trusts will be possible once national figures are published, however, security managers in the FT are members of the National Association of Healthcare Security.</li> <li>• Anonymous information on physical assaults is shared with NHS England and locally with other hospitals.</li> <li>• Regular meetings are held with the Police.</li> <li>• The availability of staff sickness information related to incidents through the Workforce report.</li> <li>• This paper should be discussed at the Workforce Committee with recommendations made to the Health and Safety Committee and the Quality Committee.</li> </ul> <p>The Committee noted the report.</p>	<p>Director of Finance</p>
Q.6.18.7	<p><b>Integrated Quality: Board Dashboard</b></p> <p>LS discussed the Quality Dashboard.</p> <ul style="list-style-type: none"> <li>• Mortality graphs for Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-Level Mortality Indicator (SHMI) charts are only illustrated to September/October 2017 due to the delay since EPR was introduced in submitting data for mortality. These are expected to be brought up to date retrospectively.</li> <li>• Figures on pressure ulcers are now reduced for the past two months and are back at the baseline.</li> <li>• KD noted an additional graph regarding complaints had been included indicating closed complaint cases and KD explained the background regarding the implementation of the EPR and patient flow requirements. The target is for 90% of complaints to be completed, within the agreed timescale, by January 2019 and 95% by March 2019.</li> </ul>	

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	<ul style="list-style-type: none"> <li>A revised dashboard of high priority training will be presented in July due to changes to refresher and new starter training.</li> </ul> <p>The report was noted by the Committee.</p>	
<b>Q.6.18.8</b>	<p><b>Falls Update Presentation</b></p> <div data-bbox="347 517 411 577" data-label="Image"> </div> <p>Q.6.18.8 - Falls update for Quality Cc</p> <p>SF was welcomed to the meeting. The Falls Prevention Group meets monthly and is attended by a number of staff from separate disciplines. Members from the respective wards where the falls occur attend the panel to discuss lessons learned. The group's guidelines are based on national guidance from The Royal College of Physicians. Action plans are discussed at safety huddles and monitored through Divisional Governance meetings and through the monthly Falls Prevention Group. Falls collaborative work commenced last September and SF noted the work currently around reporting structures, grading falls on Datix with guidance on severity of patient safety incidents around falls.</p> <p>The number of total falls versus the number of individuals that had fallen was noted of particular interest. A falls collaborative was commenced in September 2017 with 11 wards, and will complete in September 2018. Since the launch there have been four collaborative sessions where the wards have shared practices and progress on reducing falls for patients, around the environment, staff education and training, communication and practice. The teams are working together to produce a falls change package to share across all wards.</p> <p>SF described the bleep system set up for falls/Root Cause Analysis. This flagged up a lack of knowledge with some staff at Matron level, however, has resulted in added benefit and training. TC noted this was positive assurance.</p> <p>BG noted the collaborative is about allowing time for improvements to be worked to. A good reporting culture was noted across the organisation with claims, complaints and incidents being cross-referenced. Poor documentation resulted last year in a number of claims, however, this is now a much improved reporting process. KD noted if falls are discussed during walkrounds the staff are enthused. Support has been requested from the Improvement Academy.</p> <p>The presentation was noted by the Committee.</p>	
<b>Q.6.18.9</b>	<p><b>Serious Incident (SI) Report</b></p> <p>TC discussed the SI report noting two new SIs during May 2018 with one being declared a Never Event related to the wrong route of administration of medication. Two SIs were concluded during May 2018, one relating to a pulmonary embolism and the other relating to an intracranial haemorrhage secondary to a fall. A further Never Event had been reported in Maternity Services during June 2018 regarding a retained swab following a perineal repair. Full discussion and a debrief had been held and immediate learning put in place to include weekly checks.</p>	


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	<p>KD noted the high level of scrutiny currently within Maternity, the Improvement Plan demonstrating improvement in areas following The Royal College of Obstetrician and Gynaecologist's report and the cases which are becoming increasingly more complex.</p> <p>BG noted the challenges lie within the qualitative and quantitative information to provide the required levels of assurance and the Bradford Improvement Programme currently undertaking a quality improvement section in Maternity.</p> <p>The Executive Directors were welcome to suggestions from the Non-Executive Directors as to assurances to be measured. The two completed SIs were discussed in detail and the areas of learning noted.</p> <p>The report was noted by the Committee.</p>	
<p><b>Q.6.18.10</b></p>	<p><b>Infection, Prevention and Control Annual Report 2017-18 and Annual Work plan 2018-19</b></p> <p>KD highlighted the following:</p> <ul style="list-style-type: none"> <li>• Hand hygiene and spot check audits are being reinforced to confirm assurance and reassurance.</li> <li>• Positive changes have been identified as a result of the appointment of the new Nurse Consultant post.</li> <li>• Ward 22 (Cardiology) providing a service above and beyond, following the high incidence of flu over the winter months.</li> <li>• Blood stream infections were reduced last year, following a work programme, and this is now replaced with an analysis and focus on hygiene standards.</li> <li>• Work on surgical site surveillance is an area of focus where it is hoped to capture audits undertaken by junior doctors.</li> <li>• C-difficile infections have reduced through the year and a comprehensive work plan around antibiotic stewardship will be undertaken.</li> </ul> <p>The appendix work plan endorsed by Infection Control was approved by the Committee for 2018/19 and the report was noted.</p>	
<p><b>Q.6.18.11</b></p>	<p><b>Nurse Staffing Data Publication Report – May 2018</b></p> <p>KD reported for the second month the compliance percentage fill rates for registered nurses at Bradford Royal Infirmary has improved. Additional improvements should be visible in the forthcoming months.</p> <p>The report was noted by the Committee.</p>	
<p><b>Q.6.18.12</b></p>	<p><b>Maternity Annual Services Report 2017-18</b></p> <p>KD discussed the annual summary and report of the activities of the Maternity Service at Bradford Teaching Hospitals during 2017/18. The main body of the report was omitted from circulation in error, however, this has now been circulated. The report noted incidents, lessons learned, perinatal mortality, governance and risk processes, infection control and policies and guidelines, patient experience and feedback. KD noted 2017/18 had been a challenging year for Maternity Services and discussed key priorities and challenges of the Division:</p> <ul style="list-style-type: none"> <li>• Maternity Voice Partnership.</li> <li>• New initiatives around better births and continuity of care.</li> </ul>	




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	<ul style="list-style-type: none"> <li>• Teenage pregnancies.</li> <li>• Safeguarding issues.</li> <li>• Maternity Improvement Plan.</li> <li>• Mandatory Training and Appraisal rates.</li> <li>• Increased staffing in obstetric theatres.</li> <li>• Maternity Assessment Centre.</li> <li>• 25 new midwives to commence in September/October 2018.</li> <li>• Reduction in still births.</li> <li>• Reduction in Serious Incidents.</li> </ul> <p>The report will be submitted to the Board of Directors in July and presented by the team. KD requested any comments by Tuesday, 3 July 2018.</p> <p>Going forward a quarterly Maternity Report will be brought to the Quality Committee and the Committee were asked to email KD of any information for inclusion. KD will discuss further with BG, TC and the Chief Operating Officer.</p>	<p>Chief Nurse</p> <p>Chief Nurse</p>
Q.6.18.13	<p><b>Information Governance (IG) Report</b></p> <p>In CF's absence the Quality Committee received the report noting Mandatory IG Refresher training compliance was at 99% and induction at 100% as at 30 April 2018. BG noted that following the successful IG training run alongside EPR training last year, a Task and Finish Group has been set up to review training options for the year in view of this annual training expiring during August and September for large numbers of staff.</p> <p>The report was noted by the Committee.</p>	
Q.6.18.14	<p><b>Sentinal Stroke National Audit Programme (SSNAP) Update</b></p> <p>Due to sickness by the planned presenters today's stroke presentation had been deferred until the July meeting. BG discussed the draft SSNAP report in advance of the national publication of the latest data. Three elements were noted:</p> <ul style="list-style-type: none"> <li>• The Trust overall score remains at a level E although there has been an improvement in the actual score.</li> <li>• Team level score achieved a D rating (full care in Bradford).</li> <li>• Patient level scores (those who received Hyper-Acute Stroke Unit (HASU) care in other Trusts) remained at a level E.</li> </ul> <p>The improvement programme paper presented to the Quality Committee in June identified progress made in high level metrics and significant improvement work over the period March to June showing significant improvements in a number of areas. Unfortunately the latest national report covered the period December 2017 to March 2018 and it was noted there was insufficient time to undertake improvement work to influence the score in this reporting period.</p> <p>BG informed the Committee that additional actions are being taken in light of the latest report:</p> <ul style="list-style-type: none"> <li>• An expanded dataset for monitoring progress is being developed.</li> <li>• The Clinical Director from the recently visited Trust will undertake an external validation exercise of our improvement work.</li> </ul>	

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	<p>The Committee noted the report and will received a detailed review of stroke services at the meeting in July.</p>	
<p><b>Q.6.18.15</b></p>	<p><b>Management of Venous Thromboembolism (VTE) Update on Progress</b>            BG presented the report noting significant progress had been made in VTE assessments and noting sustainable improvements towards achieving the 95% standard.</p> <p>Performance for the three months (March to May 2018) demonstrates that targeted quality improvement work alongside responsiveness to daily EPR data has shown an improvement (average of 94.7%). VTE Management and the establishment of the Thrombosis Group will be discussed at the forthcoming Haematology Summit.</p> <p>The report was noted by the Committee.</p>	
<p><b>Q.6.18.16</b></p>	<p><b>Assurance, the way forward</b></p> <div data-bbox="347 913 411 981" data-label="Image">  </div> <p>Q.6.18.16- Assurance the way fc</p> <p>TC noted this presentation is being provided to every Committee in the FT and was presented to the Finance and Performance and Major Projects Committees this morning which prompted good discussions. TC had been challenged to create a virtuous cycle of assurance optimising full assurance.</p> <p>The assurance base was discussed noting:</p> <ul style="list-style-type: none"> <li>• Established governance frameworks.</li> <li>• Clearly defined strategic objectives.</li> <li>• Effective internal controls.</li> <li>• Maturing risk management culture, with the end point for reasonable assurance being a balance between strategy, risk and control.</li> </ul> <p>The virtual cycle of assurance around assurance, objectives, risks and controls were described around the Risk Management Strategy.</p> <p>The key for the organisation is to develop a system that creates and maintains a portfolio of evidence based assurance, understanding the nature of value and assurance tools. Clinical audit are undertaking a governance tool redesign over the next quarter and the Board Assurance Framework and the Datix model are under review to assist with compliance.</p> <p>LS requested the Committee feed any comments to TC directly. BG noted the importance of qualitative healthcare which is not always quantifiable. Specialty portfolios providing evidence are being created.</p> <p>TC will submit a paper to the Board of Directors in due course.</p> <p>LS noted this positive piece of work providing confidence to the Committee.</p>	<p>Director of Governance and Corporate Affairs</p>



No.	Agenda Item	Action
<p><b>Q.6.18.17</b></p>	<p><b>Fundamental Standards (Care Quality Commission (CQC)) Quarterly Report</b></p> <p></p> <p>Q.6.18.17 - CQC presentation.pdf</p> <p>TC presented the CQC update, 'Moving to Good, being Outstanding', discussed previously at the Board development day and discussed the comparisons of the previous and current CQC regimes with this moving towards a targeted risk based approach, initiated with the issue of Provider Information Request. The inspection report had been recently received with the overall rating for the Trust as requires improvement, but as two of the services not inspected on this visit had elements of requires improvement the hospital has not been able to raise its overall rating. Good ratings were received for Caring and Well-Led services.</p> <p>TC discussed the compliance actions in the report to respond to, eg must, should and could dos. Eight 'must do' compliance actions were noted, two in Medical Care services and six in Maternity, 41 'should do' recommendations and 22 optimising actions. A response will be submitted to the CQC in July prior to discussion at the Board of Directors, with an action plan compiled and circulated to the Quality Committee in July 2018 pre-Board.</p> <p>TC noted the presentation discussed at the Board Development Day around strengthening the compliance management system to achieve and exceed ISO 6900 standards through the Work as One Steering Group.</p> <p>Lessons have been learned and the development of the quality strategy plan for 2018/19 must not loose site of fundamental standards.</p> <p>The presentation was noted.</p>	<p>Director of Governance and Corporate Affairs</p>
<p><b>Q.6.18.18</b></p>	<p><b>Combined Learning Report (Work plan)</b></p> <p>TC discussed the document providing an overview of the work of, and outcomes from the Trust organisational learning response system during quarter 4 2017/18. The report was noted by the Committee.</p> <p>Further discussions will be held at the Quality of Care Panel meeting where it is hoped new consultants will become involved in this work in relation to patient experience, quality and learning. Learning matters information will be circulated to all areas in order to further engage staff.</p>	
<p><b>Q.6.18.19</b></p>	<p><b>Board Assurance Framework (BAF)</b></p> <p>LS discussed the BAF and noted the risks. PP noted the agenda item should reconfirm the risk appetite following the earlier afternoon discussions.</p> <p>The FT currently has a very low threshold for risk when looking at quality of services. It is though acknowledged that quality and risk appetite is linked to finance and performance.</p>	

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Q.6.18.20 Q.6.18.20.1	<p><b>Any Other Business</b></p> <p>Quality Oversight System</p>  <p>Q.6.18.20 - Quality Oversight System Jur</p> <p>The Quality Oversight System ensures effective processes for managing risks and issues and TC noted this will be a regular agenda item. Daily risk reviews and daily risk huddles occurred on 100% of days.</p> <p>Fifteen incidents were noted to have been referred to the Quality of Care Panel, Management Group and the Learning and Surveillance Hub.</p> <p>TC will explore opportunities for funding through the Health Foundation and Wellcome Trust.</p>	
Q.6.18.21	<p><b>Matters to share with other Committees</b></p> <ul style="list-style-type: none"> <li>• Workforce issues - Security and staffing.</li> </ul>	
Q.6.18.22	<p><b>Matters to Escalate to the Corporate Risk Register</b></p> <p>There were no matters to escalate to the Corporate Risk Register.</p>	
Q.6.18.23	<p><b>Matters to Escalate to the Board of Directors</b></p> <ul style="list-style-type: none"> <li>• Maternity.</li> <li>• Stroke Service.</li> </ul>	
Q.6.18.24	<p><b>Items for Corporate Communications</b></p> <ul style="list-style-type: none"> <li>• Infection Prevention and Control.</li> </ul>	
Q.6.18.25	<p><b>Date and time of next meeting</b></p> <p>Wednesday 25 July 2018, 2 pm to 5 pm, Conference Room, Field House, Bradford Royal Infirmary.</p>	

**BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST**  
**ACTIONS FROM QUALITY COMMITTEE – 26 June 2018**

Date of Meeting	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
20.12.17	Q.12.17.13	<b>Maternity Improvement Programme Action Plan:</b> 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	25/07/18	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.
30.05.18	Q.5.18.18	<b>Report on the Quality Stroke care: quarterly update</b> Presentation on update on stroke	Medical Director	25/07/18	18/07/18: This is included on the July Committee agenda. Complete.
30.05.18	Q.5.18.25	<b>Draft Internal Audit Plan</b> 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	25/07/18	18/07/18: Trust Secretary emailed Internal Audit regarding correction. Complete.

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30.05.18	Q.5.18.6	<b>Focus On: The Maternity Improvement Programme</b> 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	27/06/18: Evidence of assurance to be included via the Office of Governance and Corporate Affairs. 18/07/18: On July agenda. Action concluded.
30.05.18	Q.5.18.13	<b>Safeguarding Adults Annual Report and Safeguarding Children 2017-18</b> 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	27/06/18: KD to advise Safeguarding Adults Board of concerns raised relating to Local Authority response to assessment of DoLS. 18/07/18: KD raised at Safeguarding Adults Board on 03/07/18 concerns in relation to Local Authority assessments. Action concluded.
30.05.18	Q.5.18.23	<b>Freedom to Speak Up Annual Report (including Quarter 4 Report)</b> 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.	Head of Corporate Governance	25/07/18	18/07/18: Report submitted to Workforce Committee in May 2018. Action concluded.
30.05.18	Q.5.18.23	<b>Freedom to Speak Up Annual Report (including Quarter 4 Report)</b> 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	28/11/18	Will be progressed by the new Trust Secretary. Timescale to be confirmed.  27.06.18: Due date moved to

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					November, topic to be considered for inclusion at October Board Development Session.
27.06.18	Q.6.18.6	<b>Annual Reported Physical Assaults</b> This paper should be discussed at the Workforce Committee with recommendations made to the Health and Safety Committee and the Quality Committee.	Director of Finance	25/07/18	18/07/18: Agenda item on Workforce Committee 25/07/18. Action concluded.
27.06.18	Q.6.18.12	<b>Maternity Annual Services Report 2017-18</b> The report will be submitted to the Board of Directors in July and presented by the team.	Chief Nurse	25/07/18	18/07/18: On July agenda. Action concluded.
27.06.18	Q.6.18.12	<b>Maternity Annual Services Report 2017-18</b> A Quarterly Maternity Report will be brought to the Quality Committee and the Committee were asked to email KD of any information for inclusion. KD will discuss further with BG, TC and the Chief Operating Officer.	Chief Nurse	25/07/18	18/07/18: On July agenda. Action concluded.
27.06.18	Q.6.18.16	<b>Assurance, the way forward</b> TC will submit a paper to the Board of Directors in due course.	Director of Governance and Corporate Affairs	27/07/18	
27.06.18	Q.6.18.17	<b>Fundamental Standards (Care Quality Commission (CQC)) Quarterly Report</b> A response will be submitted to the CQC in July prior to discussion at the Board of Directors, with an action plan compiled and circulated to the Quality Committee in July 2018 pre-Board.	Director of Governance and Corporate Affairs	27/07/18	

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30.05.18	Q.5.18.12	<b>Nurse Staffing Data Publication Report April 2018</b> 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	29/08/18	
30.05.18	Q.5.18.27	<b>Any Other Business</b> BG to give an update from meeting with Public Health England around concerns of quality of service in Pathology.	Medical Director	29/08/18	18/07/18: Formal paper to be submitted to the August meeting.
28.03.18	Q.3.18.17	<b>Development of a real time quality dashboard – Cerner</b> 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	<b>Clinical Effectiveness Q4 Report 217-18</b> Joint presentation on Sepsis to the Quality Committee and the CCG.	Chief Nurse	26/09/18	27/06/18: TC noted the CCG have requested a deep dive into sepsis.
25.04.18	Q.4.18.11	<b>Security Management Standards for Providers</b> 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.3.18.5	<b>NICE Guidance on Rheumatoid Arthritis: Compliance and Issues</b> 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	28/11/18	Will be progressed by the new Trust Secretary. Timescale to be confirmed. 27.06.18: Due date moved to November, topic to be considered for inclusion at October Board




Date of Meeting	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
					Development Session.
28.03.18	Q.3.18.9	<b>Serious Incident Report</b> 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	<b>Briefing Paper: Trust Research Committee Update – March 2018</b> 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.

**QUALITY COMMITTEE  
MINUTES, ACTIONS & DECISIONS**

<b>Date:</b>	Wednesday 25 July 2018	<b>Time:</b>	14:00-16:15
<b>Venue:</b>	Conference Room, Field House, Bradford Royal Infirmary	<b>Chair:</b>	Professor Laura Stroud Non-Executive Director
<b>Present:</b>	<p><b>Non-Executive Directors:</b></p> <ul style="list-style-type: none"> <li>- Professor Laura Stroud, Non-Executive Director (LS)</li> <li>- Ms Selina Ullah, Non-Executive Director (SU)</li> <li>- Mr Amjad Pervez, Non-Executive Director (AP)</li> <li>- Mr Jon Prashar, Non-Executive Director (JP)</li> </ul> <p><b>Executive Directors:</b></p> <ul style="list-style-type: none"> <li>- Dr Tanya Claridge, Director of Governance and Corporate Affairs (TC)</li> <li>- Dr Bryan Gill, Medical Director (BG)</li> <li>- Ms Cindy Fedell, Director of Informatics (CF)</li> <li>- Ms Karen Dawber, Chief Nurse (KD)</li> </ul>		
<b>In Attendance:</b>	<ul style="list-style-type: none"> <li>- Professor Clive L Kay, Chief Executive (CLK)</li> <li>- Dr S Maguire, Consultant in Stroke Medicine (SM), for Q.7.18.5</li> <li>- Ms S Shannon, Chief Operating Officer (SS), for Q.7.18.7</li> <li>- Mr Paul Pallister, Trust Secretary (PP)</li> <li>- Ms Juliet Kitching, PA (Minutes)</li> </ul>		
<b>Observer:</b>	<ul style="list-style-type: none"> <li>- Dr Mark Stubbington, Senior Anaesthetic Trainee</li> </ul>		

No.	Agenda Item	Action
<b>Q.7.18.1</b>	<b>Apologies for Absence</b> There were no apologies.	
<b>Q.7.18.2</b>	<b>Declaration of Interests</b> There were no declarations of interest.	
<b>Q.7.18.3</b>	<p><b>Minutes and Actions of the Quality Committee meeting held on 27 June 2018</b></p> <p>Subject to the following changes the minutes were accepted as a correct record:</p> <p>Q.6.18.6 – Page 2, bullet point four, sentence to be added at the end of the bullet point, ‘Discussions have taken place and work in this area is underway.’.</p> <p>Q.6.18.9 – Page 5, third paragraph to read, ‘The Executive Directors were welcome to suggestions from the Non-Executive Directors as to assurances to be measured.’.</p> <p>Q.6.18.16 – Page 7, paragraph one, sentence two, ‘TC has been challenged to create a virtuous cycle of assurance optimising full assurance.’.</p>	

No.	Agenda Item	Action
Q.7.18.4	<p><b>Matters Arising</b></p> <p>The Committee noted that the following actions had been concluded:</p> <p>Q.5.18.18 (30.05.18) – Report on the Quality Stroke care: quarterly update.</p> <p>Q.5.18.25 (30.05.18) – Draft Internal Audit Plan.</p> <p>Q.5.18.6 (30.05.18) – Focus On: The Maternity Improvement Programme.</p> <p>Q.5.18.13 (30.05.18) – Safeguarding Adults Annual Report and Safeguarding Children 2017-18.</p> <p>Q.5.18.23 (30.05.18) – Freedom to Speak Up Annual Report (including Quarter 4 Report).</p> <p>Q.6.18.6 (27.06.18) – Annual Reported Physical Assaults.</p> <p>Q.6.18.12 (27.06.18) – Maternity Annual Services Report 2017-18.</p> <p>Q.6.18.12 (27.06.18) – Maternity Annual Services Report 2017-18.</p> <p>Q.6.18.17 (27.06.18) - Fundamental Standards (Care Quality Commission (CQC)) Quarterly Report</p>	
Q.7.18.5	<p><b>Focus on: Stroke Management and Care</b></p> <p></p> <p>Q.7.18.5 - Focus On - Stroke Management</p> <p>SM and the team were welcomed to the meeting to update the Committee on two recent Sentinal Stroke National Audit Programme (SSNAP) reporting periods, August 2017 to November 2017 and December 2017 to March 2018, to provide assurance that the service understands why SSNAP performance is poor and to provide details of significant improvements. Work to improve the quality of data collection was described.</p> <p>The positives and challenges of the assessment criteria were discussed.</p> <ul style="list-style-type: none"> <li>• Improved performance in 22 key indicators.</li> <li>• All stroke patients cared for at Bradford Teaching Hospitals (BTH) are defined as team centred, all patients who live in Bradford are in patient centred.</li> <li>• Team centred score achieved a level D. Patient centred remained at level E. SSNAP measures process as a surrogate of good patient outcomes.</li> <li>• Earlier care of some patients may have been influenced by the initial care received elsewhere.</li> <li>• Work has intensified over the period reported.</li> <li>• BTH were unaware the consequences of the Airedale closure of HASU would impact on BTH SSNAP data.</li> <li>• Positive changes to stroke ward configuration. Stroke rehabilitation service brought into the stroke pathway.</li> <li>• Weekly, then bi-weekly meetings chaired by BG focusing on a different part of the stroke pathway. Weekly run charts of high level metrics are now considered at each meeting along with evaluation of every patient with a diagnosis of stroke and key indicators that can be measured.</li> <li>• Discussions held with colleagues in East Lancashire who have a successful process having moved from a Level E to a B over two and a half years. The East Lancashire model has been adopted in terms of scrutiny and assessment. A provisional date has been arranged for a visit to East Lancashire.</li> <li>• Stroke responder service has been demonstrated to be robust and running</li> </ul>	

No.	Agenda Item	Action
	<p>well.</p> <ul style="list-style-type: none"> <li>• New Lead HASU nurse in post.</li> <li>• Current performance discussed and complex pieces of work are underway across the Emergency Department, Radiology and the ward in order to improve current positions further.</li> <li>• Improved quality of service to patients with assessments now taking place within 24 hours and the introduction of weekend assessments.</li> <li>• Early supported discharge process.</li> <li>• Recruitment and staff morale is positive and is driving improvement.</li> <li>• Increased confidence in the real-time detailed data which is now available and is required in order to demonstrate improvements.</li> <li>• BRI sent first regional thrombectomy patient to Leeds.</li> <li>• Percentage of eligible patients given thrombolysis in Bradford is above the national average.</li> </ul> <p>The next steps were considered.</p> <ul style="list-style-type: none"> <li>• Variation of the programme.</li> <li>• Impact in relation to how to deliver a more effective 'front door' stroke care within the context of emergency care performance.</li> <li>• To replicate the real-time data set developed by East Lancashire.</li> <li>• Programme to develop a single Airedale/Bradford Stroke Service has now started with the appointment of the programme manager.</li> </ul> <p>CLK noted the much improved position, with the staff and processes operating in a co-ordinated way. The FT's trajectory for the next reporting period based on the sustained improvement is expected to be Level D, with results available end August/early September.</p> <p>BG noted the system-wide improvements required for developing a single service with Airedale (currently Level D), as Airedale patients referred to BTH will be included in Foundation Trust's (FT) data.</p> <p>Whilst expressing concerns the Committee noted the departmental vision and the massive team effort conveyed through the presentation along with a passion for ownership of the service in order to bring about the changes in culture, required to improve the SSNAP performance.</p> <p>The Committee looked forward to recording the continued progress of changes envisaged in order to create capacity to increase performance and deliver a robust service for delivering care at the required level to patients. A combined Airedale/Bradford report will be submitted to the September Quality meeting.</p> <p>CLK thanked BG, SM and the team for the vast improvements which have been and continue to be made to the service provision.</p>	Medical Director
Q.7.18.6	<p><b>Maternity Improvement Programme Quarter 1 Update</b></p> <p>SS was welcomed to the meeting to update the Committee on the activities of the Maternity Service during Quarter 1 2018/19 including the key improvements/challenges and priorities and to provide assurance that actions from reviews, including the Care Quality Commission (CQC) report are being addressed and managed. SS highlighted the following:</p> <ul style="list-style-type: none"> <li>• Midwifery Staffing – Additional staff establishment to provide 24 hour</li> </ul>	

No.	Agenda Item	Action
	<p>theatre scrub team staff has been approved. This will reduce the risk of midwives not being able to provide 1:1 care in labour and having to care for more than one woman at a time. To date an additional two scrub staff have been appointed. In addition, a training programme is in place for midwives to refresh/upskill scrub training in theatre.</p> <ul style="list-style-type: none"> <li>Enhanced payment has also been agreed for staff working extra shifts in theatre to ensure optimum staffing levels are in place.</li> <li>Support/mentorship/professional development in place for newly qualified staff.</li> <li>The Maternity Assessment Centre is now staffed 24 hours a day.</li> <li>Safety and quality checking system in place has shown significant improvement.</li> <li>A Be the Best Improvement Group has been set up aiming to move the unit to CQC outstanding rating.</li> <li>All women who attend the Department for basic care are equally as important as complex cases.</li> <li>The most recent regional clinical outcome data available for Quarter 3 was reviewed.</li> </ul> <p>LS noted the work undertaken around quality assurance of basic systems and processes and the improvement in multi-disciplinary responsibilities. The further recent engagement from the medical staff was also highlighted. Improvements in productivity and performance were recognised.</p> <p>The Committee noted reassurance from the report that the actions will be sustained.</p> <p>BG referenced a letter, dated 25 July 2018, recently received from the Vice President of Clinical Quality at The Royal College of Obstetricians and Gynaecologists (RCOG) which stated, 'The assessors are pleased with the progress that has been made from reviewing the Trusts' Maternity Service Improvement Plan in relation to the RCOG recommendations that reported in September 2017. It is encouraging to see that Datix has been updated and piloted and has received good feedback. The assessors were unable to comment further as the maternity service improvement plan did not have the detailed information or evidence needed for each of the RCOG recommendations. The assessors and the College would like to commend the Trust for their hard work in addressing the issues identified and hope that the Trust continues to make progress. ... any further assistance from the College, please do not hesitate to get in touch.' The Committee noted this assurance.</p> <p>TC suggested that an assurance portfolio be developed to sit with the action plan. The proposal will be submitted to the August meeting.</p> <p>CLK noted the Executive team is aware of the concerns around the Division and that full support is available to the Division as necessary.</p> <p>BG noted the vast improvement made since 2016 and suggested this current information is produced on a run chart in any future reports.</p>	<p>Director of Governance and Corporate Affairs</p>
Q.7.18.7	<p><b>Quality Committee Dashboard</b> LS highlighted the key issues of the report.</p>	

No.	Agenda Item	Action
	<p><u>Night time transfers</u> – The improvements were noted. KD noted out of hours transfers take place for clinical reasons and due to bed pressures to ensure most appropriate patients within a specialty bed. Transfers try to be avoided between midnight and 6 am.</p> <p><u>Readmission Non-electives</u> – The improvements were noted. Sandra Shannon, Chief Operating Officer, will look at readmissions, as a whole, following the introduction of EPR. CF noted the Business Intelligence and Performance teams were looking at data quality issues and issues around readmissions. This information will be available in next month's report.</p> <p><u>Mortality</u> – BG noted positive HED data for HSMR had now been received, this information having been submitted through ESR.</p> <p><u>Venous Thromboembolism (VTE)</u> – The average VTE Assessment performance for the last three months is at 95%, reaching the required standard.</p>	
Q.7.18.8	<p><b>Serious Incident (SI) Report</b> TC requested that in order for this report to be fully up-to-date the report be tabled at the meeting in the future. Currently any issues at the beginning of each month are not documented in a report until the end of the following month, due to the timing of the circulation of papers. The Committee approved this proposal.</p> <p>TC informed the Committee of a Serious Incident declared this week regarding new born screening in Maternity. The Quality of Care Panel has declared the incident.</p> <p>The report was noted by the Committee.</p>	
Q.7.18.9	<p><b>Central Alerting System (CAS) Quarter 4 2017/18 Report</b> The report was noted by the Committee.</p>	
Q.7.18.10	<p><b>Nursing Staffing Data Publication Report - June 2018</b> KD highlighted three issues: <u>Ward 28</u> – The Registered nurse fill rate is 58%. Beds on Ward 28 have been ring-fenced for elective orthopaedic surgery. On a Friday afternoon until Monday afternoon the bed base is reduced and the ward has been closing on a Sunday. At times of reduced patient numbers nurses are moved to support other areas.</p> <p><u>Maternity</u> – An increased number of incidents around staffing in Maternity were noted over the month, however, all were rated as low harm.</p> <p><u>Acute Medical Unit (AMU)</u> – The Unit was currently rated as red for the ward accreditation. At the end of June the AMU was split back into two wards (Wards 1 and 4). Following ward accreditation one ward is now rated green and the other amber, identifying significant improvement.</p> <p>The Committee noted the assuring Committee for this report is the Workforce Committee, however, patient safety incidents would be raised at the Quality Committee.</p>	



No.	Agenda Item	Action
	<p>BG noted the positive changing culture in ownership within the FT proving indicators of success with concerns/issues being recognised and highlighted by staff responsible for services. The improvements were noted by the Committee.</p>	
Q.7.18.11	<p><b>Public Health England Pathology Meeting</b> BG informed the Committee he had met with representatives from Public Health England on 24 July 2018, reporting a very positive meeting and Public Health England had expressed their assurance by the work undertaken. BG was provided with verbal confidence of Public Health England's satisfaction that laboratories are running well and BG will provide a written response to this Committee in due course.</p>	Medical Director
Q.7.18.12 Q.7.18.13	<p><b>Information Governance (IG) Report</b> <b>Senior Information Risk Owner (SIRO) Report</b> CF discussed the two reports together as one was a monthly report and the other a quarterly report. Given the position of the Trust in terms of Information Governance the quarterly report has taken a retrospective review to provide clarity of the position to date and inform the next steps in the Trust's ambition of being a mature IG organisation. She also noted that both the introduction of the General Data Protection Regulation (GDPR) and Data Protection Act 2018, and the change of the Information Governance Toolkit this year to the Data Security and Protection Toolkit, which focuses on security, forms part of this position.</p> <p>The Trust has seen a significant and sustained reduction in reportable incidents over the years. IG incidents as a whole have also decreased in severity. Training is at 99% and training at induction is at 100% as at 30 April 2018. The training position continued to improve post Electronic Patient Record (EPR) Training, which included IG training, demonstrating strong awareness and improved maturity. There is one open reportable incident that involved access to the EPR. TC reported the investigation into the incident noted the unique circumstances and key learning for the organisation. The Trust is now considering a changed approach to the delivery of training considering the position. It is proposed the training focus is on information governance with the EPR and cyber security awareness for staff. The Sub-Committee will consider a proposal for a changed approach next month.</p>	
Q.7.18.14	<p><b>Quarterly Risk Management Report Q1</b> TC discussed the key issues within the report.</p> <p>Staff survey responses indicated staff do not report incidents, however, the latest bi-annual report received from the National Reporting and Learning System between 1 April and 30 September 2017, demonstrated no evidence of under-reporting in the FT. The new Datix form enables incidents to be graded directly and therefore can be uploaded in a more timely way. Training is available to assist staff in understanding how to grade incidents. The profile of incidents within the FT was questioned. TC noted the three Never Events in Maternity since January 2018.</p> <p>A list of the top five moderate harm incidents were noted for information:</p> <ul style="list-style-type: none"> <li>Blood transfusion incidents.</li> </ul>	

No.	Agenda Item	Action
	<ul style="list-style-type: none"> <li>• Patient fall, slips or trip on same level.</li> <li>• Medication.</li> <li>• Discharge of patients.</li> <li>• Patient fall from height.</li> </ul> <p>There were no incidents that met the criteria for serious hazards of transfusion reporting and it was noted the Blood Transfusion Committee regularly review all incident data. The Patient Safety Sub Committee will link with the Medicines Safety Group and undertake a review of dispensing incidents in order to ascertain the themes.</p> <p>The ProGRESS responsive review report will be submitted to Divisions to support analysis of their incidents relating to patient discharge. A new approach to analysing claims has been introduced following increased information now being provided by NHS Resolution.</p> <p>All information related to precursor incidents is used by the Learning Hub. KD noted historical data will be reviewed once specific improvement plans are in place. In the future it is envisaged areas of high risk will be identified. CLK noted the FT are working with GE around the introduction of a Command Centre to introduce a quality tile which will display quality information in real time.</p> <p>The Committee noted Schwartz rounds are being launched from August 2018 and results of the staff survey will be discussed at the Workforce Committee.</p> <p>KD suggested adding in the date to the historical cases within the report and a description of alleged failures in order to provide context.</p> <p>The Committee accepted the very comprehensive report.</p>	
Q.7.18.15	<p><b>Quality Oversight System</b></p> <p>The themes identified this month reflect those reported previously around delays in, and missed appointments. Medication incidents in prescribing and dispensing rather than administration have been highlighted and the Medicines Safety Group are investigating no harm incidents around chemotherapy. Learning matters around diabetes will be issued over the next few weeks following low/no harm incidents. Documentation pertaining to the management of patients absconding from wards (particularly in relation to Deprivation of Liberty/Mental Health Act) and medication errors are being considered. Learning matters regarding equipment and safety checks in relation to Sharps safety and the management of Sharp bins will be compiled.</p>	
Q.7.18.16	<p><b>Review of Terms of Reference of the Quality Committee</b></p> <p>LS drew the Committee's attention to the changes highlighted within the Terms of Reference. Attendance is monitored and published in the Trust's Annual Report.</p> <p>KD queried as clinical issues are raised at the Finance and Performance Committee should consideration be given for the Chief Operating Officer to attend this Committee. CLK noted a review of all Committee attendance will be undertaken in September 2018.</p>	

No.	Agenda Item	Action
	<p>CF requested her Deputy remain as the Associate Medical Director for Informatics.</p> <p>Subject to the above, the Terms of Reference will be recommended by this Committee to the Board of Directors.</p>	
<p><b>Q.7.18.17</b></p>	<p><b>Care Quality Commission (CQC) In patient Survey 2017</b>            KD reported the anonymous results of the survey undertaken prior to July 2017, to be marginally improved on last year's outcomes, however, further improvement is required. The report notes full benchmarking across all NHS Trusts. The response rate was noted as significantly below the national average at around 40%.</p> <p>Discussions regarding results have been held at the Executive Management Team and shared with Clinical Divisions. Workshops have been organised with Divisions and improvements made focusing on under-performing areas. Bi-monthly updates are submitted to the Patient First Committee. TC noted the improvements made to promote increased friends and family responses.</p> <p>CLK expressed his concerns, however, noted the work underway. Results and comments will feed into the Patient Experience Strategy. The next report will be submitted to the Committee in October/November. Learning points were referenced by the Committee members. BG noted the information required from patients for each doctor validating and the importance of aligning the different pieces of work available in the FT.</p> <p>TC noted evidence of improvement work is required for the Quality report and suggested a patient experience focus session may prove useful.</p> <p>The report was accepted.</p>	
<p><b>Q.7.18.18</b></p>	<p><b>Learning Disability Improvement Standards for NHS Trusts</b>            KD reported in June 2018, NHS Improvement launched the Learning Disability Improvement Standards for NHS Trusts with four standards aimed at improving the care received:</p> <ul style="list-style-type: none"> <li>• Respecting and Protecting Rights.</li> <li>• Inclusion and Engagement.</li> <li>• Workforce.</li> <li>• Specialist Learning Disability Service Standards.</li> </ul> <p>A number of actions were proposed over the next twelve months to embed into practice. The action plan will be compiled and submitted to this Committee.</p> <p>JP raised the issue of obtaining permission from patients or their advocate to flag on the system those patients with learning disabilities and those with undiagnosed learning disabilities. KD will seek clarification.</p> <p>The report was accepted.</p>	<p>Chief Nurse</p> <p>Chief Nurse</p>
<p><b>Q.7.18.19</b></p>	<p><b>Mothers and Babies: Reducing Risk Through Audits and Confidential Enquiries Across the UK (MBRRACE-UK) 2016 Perinatal Mortality Report</b>            LS noted this clear and concise report brought to the Committee identifying the progress and performance of BTH in comparison with other Trusts.</p>	

No.	Agenda Item	Action
Q.7.18.20	<p><b>Leadership Walkround Quarterly Update</b> BG reported the successful discussion recently held at the Executive Management Team meeting around leadership, engagement and walkrounds. The process is subject to change in due course, however, engagement will not be lost and follow-up on improvements will be captured.</p> <p>The report was noted by the Committee.</p>	
Q.7.18.21	<p><b>Gosport Enquiry – Summary and Implications for Foundation Trust</b> BG referenced the synopsis of the 400 page report identifying a number of overarching themes. A detailed summary will be brought back to the September meeting.</p> <p>There are no specific recommendations made in the report. Some preliminary work has already been undertaken to understand drug use both in the Acute Trust and in the Community Hospitals. Clinicians work in pairs and are able to test each other's decision making, providing a level of assurance at this time.</p>	Medical Director
Q.7.18.22	<p><b>Mortality Review Improvement Programme Update</b> Following earlier discussion, BG noted a re-energise following the introduction of the EPR. The mortality review processes will feed into the Clinical Effectiveness Group to strengthen the work already being undertaken.</p>	
Q.7.18.23	<p><b>Board Assurance Framework (BAF)</b> LS presented the Board Assurance Framework for Month 1 Quarter 2 2018/19 describing the summary of substantive changes to the Board Assurance Framework including:</p> <ul style="list-style-type: none"> <li>The proposed refresh of the Board Risk Appetite Statement had been developed following review at Board Committees for consideration by the Board of Directors.</li> <li>The change in Key Performance Indicators for Strategic Objective 1, not previously considered by the Quality Committee prior to presentation at the Board of Directors.</li> <li>The Board Assurance Framework for Quarter 1 and the Corporate Risk Register.</li> </ul> <p>Discussions were noted from the Finance and Performance and the Workforce Committees held earlier on 25 July 2018.</p> <p>TC noted strategic objectives are high level organisational objectives. Individual Department Key Performance Indicators and risks can only be included by exception. TC, BG, KD and LS agreed to meet prior to the August Quality Committee to explore further. A paper with proposed new Key Performance Indicators will be submitted to the Committee.</p> <p>LS noted on behalf of the Committee the way forward.</p>	Director of Governance and Corporate Affairs/ Medical Director/ Chief Nurse
Q.7.18.24	<p><b>Any Other Business</b> There was no other business.</p>	
Q.7.18.25	<p><b>Matters to share with other Committees</b> There were no matters to share with other Committees.</p>	

No.	Agenda Item	Action
Q.7.18.26	<b>Matters to Escalate to the Corporate Risk Register</b> There were no matters to escalate to the Corporate Risk Register.	
Q.7.18.27	<b>Matters to Escalate to the Board of Directors</b> <ul style="list-style-type: none"> <li>Stroke data.</li> <li>Maternity.</li> <li>Patient Experience.</li> </ul>	
Q.7.18.28	<b>Items for Corporate Communications</b> <ul style="list-style-type: none"> <li>Venous thromboembolism.</li> </ul>	
Q.7.18.29	<b>Date and time of next meeting</b> Wednesday 29 August 2018, 2 pm to 5 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 July 2018**

Date of Meeting	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
30.05.18	Q.5.18.12	<b>Nurse Staffing Data Publication Report April 2018</b> 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	29/08/18	
30.05.18	Q.5.18.27	<b>Any Other Business</b> BG to give an update from meeting with Public Health England around concerns of quality of service in Pathology.	Medical Director	29/08/18	18/07/18: Formal paper to be submitted to the August meeting. 25/07/18: BG met with Public Health on 24/07/18 at a very positive meeting. Verbal confidence given that Public Health assured by work done and that the FT has laboratories that are running well. Written response to be provided in due course to this Committee. 29.08.18: Item on August Agenda. Concluded.
25.07.18	Q.7.18.6	<b>Maternity Improvement Programme Quarter 1 Update</b> TC suggested that an assurance portfolio be developed to sit with the action plan. The proposal will be submitted to the August meeting.	Director of Governance and Corporate Affairs	29/08/18	
25.07.18	Q.7.18.18	<b>Learning Disability Improvement Standards for NHS Trusts</b> A number of actions were proposed over the next twelve months to embed into practice. The action plan will be compiled and submitted to this	Chief Nurse	29/08/18	



Date of Meeting	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
		Committee.			
25.07.18	Q.7.18.18	<b>Learning Disability Improvement Standards for NHS Trusts</b> JP raised the issue of obtaining permission from patients or their advocate to flag on the system those patients with learning disabilities and those with undiagnosed learning disabilities. KD will seek clarification.	Chief Nurse	29/08/18	
25.07.18	Q.7.18.23	<b>Board Assurance Framework</b> TC, BG, KD and LS agreed to meet prior to the August Quality Committee to explore further. A paper with proposed new Key Performance Indicators will be submitted to the Committee.	Director of Governance and Corporate Affairs/ Medical Director/ Chief Nurse	29/08/18	
28.03.18	Q.3.18.17	<b>Development of a real time quality dashboard – Cerner</b> 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	<b>Clinical Effectiveness Q4 Report 217-18</b> Joint presentation on Sepsis to the Quality Committee and the CCG.	Chief Nurse	26/09/18	27/06/18: TC noted the CCG have requested a deep dive into sepsis.

Date of Meeting	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
27.06.18	Q.6.18.16	<b>Assurance, the way forward</b> TC will submit a paper to the Board of Directors in due course.	Director of Governance and Corporate Affairs	26/09/18	25/07/18: TC to provide update in September.
25.07.18	Q.7.18.5	<b>Focus on: Stroke Management and Care</b> A combined Airedale/Bradford report will be submitted to the September Quality Committee.	Medical Director	26/09/18	
25.07.18	Q.7.18.11	<b>Public Health England Pathology Meeting</b> BG will provide a written response to this Committee regarding Public Health England's satisfaction that laboratories are running well.	Medical Director	26/09/18	29.08.18: Item on August Agenda. Concluded.
25.07.18	Q.7.18.21	<b>Gosport Enquiry – Summary and Implications for Foundation Trust</b> A number of overarching themes identified within the report, a detailed summary will be brought back to the September meeting.	Medical Director	26/09/18	
25.04.18	Q.4.18.11	<b>Security Management Standards for Providers</b> 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.3.18.5	<b>NICE Guidance on Rheumatoid Arthritis: Compliance and Issues</b> 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	28/11/18	Will be progressed by the new Trust Secretary. Timescale to be confirmed. 27/06/18: Due date moved to November, topic to be considered for inclusion at October Board Development Session.

Date of Meeting	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
30.05.18	Q.5.18.23	<b>Freedom to Speak Up Annual Report (including Quarter 4 Report)</b> 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	28/11/18	Will be progressed by the new Trust Secretary. Timescale to be confirmed.  27/06/18: Due date moved to November, topic to be considered for inclusion at October Board Development Session.
28.03.18	Q.3.18.9	<b>Serious Incident Report</b> 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	<b>Briefing Paper: Trust Research Committee Update – March 2018</b> 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.