Bradford Teaching Hospitals
NHS Foundation Trust

QUALITY COMMITTEE
MINUTES, ACTIONS & DECISIONS

Date:	Wednesday 28 November 2018	**Time:**	14:00-16:30
Venue:	Conference Room, Field House, Bradford Royal Infirmary	**Chair:**	Professor Laura Stroud Non-Executive Director
Present:	**Non-Executive Directors:** - Professor Laura Stroud, Non-Executive Director (LS) - Ms Selina Ullah, Non-Executive Director (SU) - Mr Amjad Pervez, Non-Executive Director (AP) - Mr Jon Prashar, Non-Executive Director (JP) **Executive Directors:** - Ms Cindy Fedell, Chief Digital and Information Officer (CF)		
In Attendance:	- Dr Tanya Claridge, Director of Governance and Corporate Affairs (TC) - Dr LeeAnne Elliott (LAE), Deputy Medical Director, representing Dr Bryan Gill - Ms Sally Scales (SS), Deputy Chief Nurse, representing Ms Karen Dawber - Ms Claire Chadwick (CC), Nurse Consultant, Infection Control in attendance for Q.11.18.11 - Dr Andrew Daley (AD), Consultant in Palliative Medicine, and Ms Elizabeth Price (EP), Lead Nurse for Palliative Care in attendance for Q.11.18.12 - Ms Juliet Kitching, PA (Minutes)		

No.	Agenda Item	Action
Q.11.18.1	**Apologies for Absence** Dr Bryan Gill, Medical Director (BG) Ms Karen Dawber, Chief Nurse (KD)	
Q.11.18.2	**Declaration of Interests** There were no declarations of interest.	
Q.11.18.3	**Minutes and Actions of the Quality Committee meeting held on 31 October 2018** The minutes of the last meeting were approved as a correct record.	
Q.11.18.4	**Matters Arising** The Committee noted that the following actions had been concluded: Q.8.18.13 (29.08.18) – Clinical Effectiveness Quarter 1 Report 2018-19 Q.8.18.13 (29.08.18) – Clinical Effectiveness Quarter 1 Report 2018-19 Q.8.18.16 (29.08.18) – Palliative Care Annual Report Q.9.18.20 (26.09.18) – Maternity Quality Dashboard Q.10.18.7 (31.10.18) – Quality Committee Dashboard Q.10.18.10 (31.10.18) – Maternity 'Be the Best' Programme Q.10.18.10 (31.10.18) – Maternity 'Be the Best' Programme Q.10.18.20 (31.10.18) – Model Hospital Briefing. Q.10.18.24 (31.10.18) – Matters to Escalate to the Board of Directors Q.3.18.9 (28.03.18) – Serious Incident Report	

No.	Agenda Item	Action
	LS noted the welcomed improvement to the way data is presented in papers received at the Quality Committee, following discussions and challenges faced over the last few months.	
Q.11.18.4.1	**Matters Arising from the Board of Directors** Quality Dashboard - Never Events: The Board requested the Committee consider whether it felt assured or reassured and assured that the early warning indicators are picked up to identify where there may be something systemic of concern. The Committee were satisfied they were assured, following consideration, discussion and questioning of the reports and action plans. TC suggested that the Quality Oversight summary could be strengthened with early warning and be reviewed in more detail. Issues that are of concern, but are not a safety concern, require careful consideration, as do concerns over repeated Never Events. TC informed the Committee of a Never Event recently declared, noting a trend/common theme from the two previous Never Events, as a result of staff taking over during a procedure. Quality Impact Assessments (QIA) (Deadline 2019) - Thresholds were raised. A random sample of QIAs will be submitted to this Committee on a regular basis with the reporting timescale added to the Committee's Work plan.	
Q.11.18.4.2	**Matters Escalated from Sub-Committees** LS reminded the Committee of the Sub-Committees of this Committee: • Children and Young People's Board. • Mortality Sub-Committee. • Integrated Safeguarding Committee. • Clinical Audit and Effectiveness Committee. • Information Governance Committee. • Patient Safety Committee. • Patients First Committee. There were no issues of note from the above Committees.	
Q.11.18.5	**Corporate Risks relevant to the Committee** TC noted the Committee is managing risks strategically noting Executive Director leadership discussions that require escalation to the Integrated Governance and Risk Committee and the Board Assurance Framework (BAF). Correct gradings of the principle risk, management of sub-committees, assurance, escalation processes and recommendations are considered.	
Q.11.18.6	**Board Assurance Framework (BAF)** The BAF provided the Committee with a profile of risks, controls and assurances related to the delivery of the Foundation Trust's (FT) strategic objectives. The key controls and associated assurance were discussed supported by the Quality Dashboard and the papers presented. The Committee agreed the transfer of responsibility of assurance associated with mandatory training be passed to the Workforce Committee with discussion at the Quality Committee by exception.	Director of Governance and Corporate

No.	Agenda Item	Action
		Affairs
Q.11.18.7	**Terms of Reference Review** TC noted the draft Terms of Reference had been amended following the Committee Self-Assessment process. The Committee noted the document was written to a high standard, was very clear and of an appropriate length. The Committee approved the submission for presentation to the Audit and Assurance Committee before being returned to the Quality Committee for approval prior to being submitted to the Board of Directors for sign-off. Due to the forthcoming management changes, titles will be updated in due course. TC noted the addition of Non-Executive Director/Associate Non-Executive Director to provide flexibility of membership if required. The Chair and Chief Executive of the Trust are able to attend any meeting and be part of that meeting. Attendance of observers would be with permission of the Chair of the Committee. TC described the diagram of reporting lines. An exception report will be submitted to each Audit and Assurance Committee from this Committee in order to provide significant assurance in terms of the governance and conduct of the Committee. The purpose statement under the diagram was noted to be excellent and exceptionally helpful. TC noted the Health and Safety Committee will cease as a Board Committee and will become a sub-committee of the Quality Committee, reporting by exception to the Workforce Committee.	
Q.11.18.8	**Quality Committee Dashboard** The dashboard provides a single view of quality and safety metrics aligned to the FT's Strategic Objectives with the information displayed provided over the last month, used as a performance management tool. LS discussed the purpose of the dashboard, gaps in assurance, areas of concerns, challenges, trends and actions to be considered further. Patient and Staff Friends and Family test baselines were raised noting the low baseline is low in comparison to other Trusts in the region. Targets need to be achievable and the thresholds agreed by the Committee. SU discussed a lack of available forms for completion on a recent walkround to the Fracture Clinic. The following red indicator areas were discussed: Catheters and Urinary Tract Infections (CAUTI) – Issues are recognised and are being addressed. The Infection, Prevention and Control report is due to the December Quality Committee, however, due to the short timescales for the next meeting, it was agreed to bring an exception report on CAUTI to the January meeting. Pressure Ulcers – New standards have been published in relation to the reporting of pressure ulcers. The FT is part of a National collaborative for pressure ulcers and had a recent visit from NHS Improvement. This is underway but the FT is currently not seeing the level of improvement required. An internal audit review of processes in relation to pressure ulcers has been undertaken. The tissue viability team are identifying actions to be	Chief Nurse

No.	Agenda Item	Action
	taken. The use of documentation in the Electronic Patient Record (EPR) is being reviewed to improve consistency and prompt practice. The Committee requested an exception report is brought to the February meeting. Night-time Transfers – The one patient listed transferred appropriately and this figure should not have been documented as an inappropriate transfer. New Starter Training – The target is 100%, the Quality Committee will ask the Workforce Committee to advise if this has been attained. Serious Incidents (SI) – This measure relates to the process and the governance around SIs. TC will discuss the RAG rating commentary with John Holden, Director of Strategy and Integration.	Chief Nurse Director of Governance and Corporate Affairs Director of Governance and Corporate Affairs
Q.11.18.9	**Maternity Quality Dashboard** SS discussed the detailed Maternity Quality Dashboard compiled by BG and KD. Due to recent scrutiny received in Maternity, a number of external regulators/organisations and the Clinical Commissioning Group (CCG) have been involved, and it has become apparent that in some cases the different organisations have been looking at a variety of different metrics. In November, KD and BG have met with NHS Improvement, who have agreed to broker agreement between all of the interested parties to devise a consistent dashboard so that the same metrics are being used across the board. The work in progress document provided an update of the position with finalization expected in the next couple of months. LS noted Maternity was previously an area of concern, however, recognised the complexities involved do not reside entirely with the FT. The document has to be owned by the CCG and this was agreed at the recent Joint Quality Committee meeting held with the CCG on 16 November 2018.	
Q.11.18.10	**Quality Oversight System** TC reported the key issue as the recently declared Never Event in relation to the removal of the wrong tooth and noted a similar Never Event was declared approximately two years ago. A rapid debrief has been undertaken with the team and a recurrent theme identified in incidents where other professionals have taken over due to complexities with the checklist not having been restarted. The incident will be operationalised via the Quality of Care Panel meeting. A further SI has been declared concerning a surgeon injecting an incorrect foot with local anaesthetic when undertaking a minor procedure on a greater toe. This was noted to not fall into the category of a Never Event and this has been confirmed by the CCG. The Workforce Committee is currently considering how learning from incidents can be embedded in training. The Committee decided that the paper provided assurance in relation to the conduct and outcomes of the Quality Oversight System.	
Q.11.18.11	**Focus on: Sepsis**	

No.	Agenda Item	Action
	Q.11.18.11 - Focus on Sepsis Quality con CC was welcomed to the meeting and delivered the above presentation providing a brief synopsis and update on the sepsis CQUIN and the progress against the national sepsis CQUIN. The following were highlighted: • Background and aims. • National sepsis CQUINs explained. • Weekly quality/performance reports developed from April 2018 with the Performance Team identifying any patient who triggers for sepsis on the EPR system, illustrating compliance of sepsis screening and sepsis treatment. • Open, honest and robust reporting system. • Screening tool switched on in June 2018 in order to identify an alert warning on the EPR system of those patients who require screening. 55% compliance for adults and 59% for children for Accident and Emergency Department (AED) admissions, slightly lower for direct admissions. The automated system is triggered through the observation process. Trigger levels discussed. • Timely antibiotic therapy within an hour of a patient triggering sepsis for adults with children slightly lower. Training and education continues internally in the Department and with clinical teams. • Ongoing Maternal Assessment Pathway trial. • Sepsis Improvement Programme is underway including the trail of a Sepsis trolley. • NEWS 2 (a triggering system for observations, has been nationally driven and is part of the sepsis CQUIN). This requires implementation by March 2019 with a go-live date of January/February 2019 after end user testing in January 2019. LS noted the important and exciting work underway. LAE noted the data from EPR is essential to drive and demonstrate improvement. Good engagement from clinicians was noted with training offered in different forums. The areas of concerns were noted, namely providing additional support to areas where patients have direct admission. Elderly care were noted to be very good at identifying sepsis in the elderly.	
Q.11.18.12	**Focus on: End of Life Care in BTHFT** Q.11.18.12 - Focus on End of Life Care ir EP and AD were welcomed to the meeting and delivered the above presentation, following submission of the annual report to the August 2018 meeting.	

No.	Agenda Item	Action
	The following were highlighted: • Achievements noted over the last year including staffing, Bereaved Carer Survey, 3rd Annual Bradford Bereavement Conference, completed data submission for National Audit of End of Care at the End of Life and the continuation of the End of Life Companions role. • Team activity – 795 referrals in 2017 to 2018. 9% increase in face to face contacts, 45% referrals for non cancer. Involvement in 21% of all hospital deaths. 50% increase in South Asian referrals over the last three years (approximately 10% of workload). 91% of urgent referrals seen on the same working day. • Provision of support from the Chaplaincy Team where appropriate. • Attendance at three Cancer Multi-disciplinary Team meetings, ie lung, upper GI and Cancer of unknown primary where an attendance rate of 95% is expected. • Team development – Retirements, combined nursing posts being considered and attachments regarding joint BTHFT and hospice projects for nursing staff. Succession planning and future workforce under consideration. Development of a detailed Business Case. • End of Life Operational group. • Last Days of Life Audit. • Death certification available in a timely manner – Role of Medical Examiner to be introduced in 2019. • Bereavement and Bereaved Carer Survey. • Recommended Summary Plan for Emergency Care and Treatment. • Educational activities – Decline in face to face teaching due in part to unfilled places, however, on-line training is available. • Last Year of Life Project – Percentage of deaths registered with Gold Line. • Clinical Commissioning Group End of Life Programme Board. • Challenges. LS noted Health Education England may have an underspend regarding training allowances. EP expressed her interest in applying when notification is received. The Committee discussed possible engagement with the University of Bradford students regarding interns/voluntary staff. The issue of the Hospital Charity Office being approached for funding for some of the smaller Trust-wide initiatives/projects was noted, however funding is not always possible as Charities are tied by rules and regulations. SS noted the Chief Nurse may be able to offer funding from a recent charity donation towards the conference. TC informed AD and EP of the results of the recent mock inspection undertaken in the service, good with outstanding features for the team and the service widely. Issues noted concerned staff being unaware of Board leaders, End of Life Care, and the appearance of the Mortuary's bereavement viewing room. TC agreed to discuss these issues at the Executive Mobilising Committee in order to ascertain how these issues can be fixed to increase the rating to outstanding. LS noted the concise, open and transparent report.	

No.	Agenda Item	Action
Q.11.18.13	**Serious Incident (SI) Report** TC reported three SIs had been declared in October, two relating to pressure ulcers. SI 2018/2549 related to a Police case and a swab being taken on a patient under sedation, without clinical indication or consent. Necessary actions had been taken and reports made to the appropriate bodies. The investigation, previously on hold, due to the Police investigation is now underway. Guidance in relation to providing information/medical evidence to the Police will be urgently reviewed and strengthened. Three SI reports were concluded in October 2018 and noted by the Committee. • SI 2018/18201 – NIPE Screening incident – The investigation concluded the guidance had not been followed and the patient will require surgery. Procedures are now in place to avoid a similar type of incident. • SI 2018/11774 – Never Event Wrong route of medication administration has been de-logged, following agreement with the CCG, as a Never Event but will be investigated as an SI. This was a knowledge based error. • SI 2018/17412 – Physician Associate Practitioner treated a patient and was later found to be under the influence of a substance on duty. All due processes were carried out in an appropriate manner and there was no evidence of any concerns around the student's practice earlier in, or during the shift. The incident is now being managed by the University of Bradford. TC noted the patient concerned did not agree with the outcome of the investigation and this is being managed separately. LS noted Physician Associates are now on the legislative programme for regulation and work under their medical dependent clinicians. This issue will be discussed at the Workforce Committee in relation to the FT's position and Quality Impact Assessments being undertaken for all new roles. The Committee decided that they were assured that there are appropriate systems and processes in place to ensure the identification, investigation and ensuring learning from serious incidents. Concerning the trending around Never Events, a thematic analysis will be submitted to the December meeting by TC, with a full discussion held at the Patient Safety Committee.	Director of Governance and Corporate Affairs Director of Governance and Corporate Affairs
Q.11.18.14	**Safeguarding Children – Bi-annual report** SS highlighted the following: • Safeguarding Children's Team are now at full capacity for staffing. • Children flagged on EPR for safeguarding concerns are frequently missed in the AED. This has been added as an item to the AED risk register. Support is being provided by the Safeguarding Children's Team. • Processes improved following learning from serious case reviews. • Successful commencement of the implementation of the Child Protection Information System, a national system where the FT can ascertain if a child is admitted and concerns are raised. The central database used by participating Local Authorities can be viewed to identify whether there is a Child Protection Plan in place, to improve safeguarding. Implemented in Maternity and planned rollout to AED. • Female Genital Mutilation Information System has also been implemented in Maternity with plans for wider FT rollout by mid-December 2018. • Children on Adult Wards - Guidance has been identified as part of the FT's	

No.	Agenda Item	Action
	Care Quality Commission (CQC) preparation. Paediatrics and the Safeguarding Team are involved in this work. Additional training needs have been identified and a risk assessment will be undertaken. This information will be added into the Ward Accreditation process. • Training Compliance for Level 3 and 3S is currently below the target level of 95% (for all levels) and the team are targeting individuals to ensure improvement in this figure. • The FT's Local Authority recently underwent an OFSTED inspection and was rated as inadequate. A risk assessment has been undertaken to identify any potential impact on the FT. The only potential of concern may be around consent and mitigation is already in place. The report was noted by the Committee.	
Q.11.18.15	**Safeguarding Adults – Bi-annual report** SS highlighted the positive report and noted the key points: • Excellent compliance for all training levels including Prevent and Wrap training. • A Learning Disability Forum has been established and the team are leading on undertaking the learning disability audit. The Forum will then devise a work plan based on the outcome of the audit. • A review of the Deprivation of Liberty Safeguards (DoLS) process was undertaken in response to changes within the Local Authority DoLS team ensuring full compliance. • Team involvement in Domestic Homicide reviews and Safeguarding Adult reviews. • Systems are in place where concerns are raised around carers and peer group pressure where there is a lack of information from the individual themselves. • Areas of focus going forward include, domestic violence and human trafficking. One member of the team is currently spending two days a week, working in AED to ensure staff pick up on flags and take appropriate action. Following discussion SS noted that if the FT make a referral relating to Prevent, the FT is not responsible for the investigation or any future actions, this is led by the Police. The report was noted by the Committee.	

Q.11.18.16	**Nursing Staffing Data Publication October 2018**
	SS highlighted the key points:
	• Slight reduction in terms of fill rates for days and nights at BRI and nights at SLH.
	• Fill rates of less than 80% for three consecutive months on:
	  • Ward 28 (days) – Significant numbers of empty beds mean there was no impact on CHPPD.
	  • Ward 31 (nights) – A reduction from 3 RNs to 2, but backfilled with HCAs.
	• Maternity - Fill rates for the Birth Centre and M3 have shown a reduction for October due to sickness and vacancies. The newly qualified midwives have now commenced but were not included within the numbers for October, resulting in lower fill rates. Robust processes are in place to mitigate the	

No.	Agenda Item	Action
	risk by closing beds on these areas when insufficient staffing levels. The report was noted by the Committee.	
Q.11.18.17	**Endoscopy JAG Accreditation** TC discussed the report previously submitted to the Finance and Performance Committee in October and following a request from the October Quality Committee for the document to be presented for a view only, as opposed any specific quality or safety concerns to note. In terms of risks and incidents there is a trigger list to identify those incidents related to patients waiting. Following any escalation the quality oversight system would indicate or identify any harm. Assurance was noted that the Committee had viewed the report from a quality perspective and the Committee decided that the existing processes for identifying harm are proportionate and appropriate.	
Q.11.18.18	**Clinical Effectiveness Quarter 2 Report 2018-19** TC noted the report provided an overview of the progress the FT had made during Quarter 2 2018/19 in discharging its responsibility in relation to the key areas within the effectiveness domains of the National Institute for Health and Care Excellence (NICE), National Confidential Enquiry into Patient Outcome and Death (NCEPOD), national and local audit and clinical guidance. The areas of concern were noted: • Delays in the implementation of NICE guidance related to the assessment of risk for and the management of Venous Thrombo-embolism (VTE). The VTE group are to commence using Datix for reporting hospital acquired clots. • Delays in the implementation of NICE guidance and the performance of the FT in the national clinical audit related to the care of people with rheumatoid arthritis. • Implementation of the NICE sepsis guidance – Information will be presented to the Commissioners and the CQC. • Case ascertainment of a number of national audits in terms of conduct and ability to obtain data in a timely way. • A number of national audits where the FT's performance in relation to specific standards has been identified as worse than expected. • Variable approach to controlling data quality – Submission and sign off. • The paediatric diabetes audit has been raised with the Commissioners, HPO1C level is noted to be a community issue. • Sensitivity of divisional governance to identify and pick up urgent risks through the audit programme. • Zero tolerance to out-of-date clinical guidelines – A plan is in place that by December, 95 to 100% of guidelines will have been updated. LAE informed the Committee early indications from the latest Sentinal Stroke National Audit Programme submission demonstrates that the FT is now at a Level B and this is testament to all the hard work that has been undertaken by the team. Clinical effectiveness throughout the FT is managed via specialties through the	

No.	Agenda Item	Action
	Divisions, who understand guidance, audits and standards that apply specifically to their specialties. The Terms of Reference of the Clinical Effectiveness Committee will be refined and presented to the Quality Committee to include mortality. The examples of good practice within the report were noted and will be shared. The level of scrutiny applied to work through the Clinical Effectiveness Committee and the team's work was recognised by the Committee. The Committee decided that it was assured that the appropriate governance is in place to manage the effectiveness programme of work, and to effectively escalate actual, emergent and latent risk.	
Q.11.18.19	**Model Hospital: Next Steps** TC noted the Model Hospital/Getting It Right First Time should be raised on each Quality Committee agenda. Management of the Programme Charter was discussed at the Finance and Performance Committee. Further work will be undertaken within the forthcoming Board session on 10 January 2019. The Quality Committee will then need to agree the elements to be considered. SS will ensure that information discussed at the nurse establishment reviews is documented within the nurse staffing paper.	
Q.11.18.20	**Information Governance (IG) Report** CF reported mandated IG training compliance is at 88% as at 31 October 2018. Preparing the new Data Security and Protection Toolkit continues. The data quality metrics in the report have been updated now, moving beyond patient demographic and pathway data, to look at data quality as a whole in the Trust. There continues to be ongoing errors in patient pathway data with this position continually improving. The indicators are provided in a scorecard-style approach looking at Business Critical Data for Operational and Clinical use, Business Critical Data for Decision Making, Validation of the Data Quality position, and Data Quality Maturity. LS noted the helpful framework. CF reported the team is almost fully staffed. The Committee suggested that instead of the two proxy indicators for external data quality metrics that these include all available reports along with perspective on the improvements impacting financial reporting. The report was noted by the Committee.	
Q.11.18.18	**Patient Experience Quarter 2 Report** SS highlighted the following: • Improvements being made to the quality and response time in relation to complaints. • Overall increase in the number of complaints received, however, the numbers replied to are reducing. • Work being undertaken in the Division of Anaesthesia, Diagnostics and Surgery to identify the reasons for the increase in complaint numbers. • Patient Administration and Liaison Service (PALS) has been rebranded resulting in an increased number of contacts. • National Maternity Survey results with a small increase in the overall score from the previous year. Further work is planned and a workshop has been	

No.	Agenda Item	Action
	organised to feedback into the overall work being carried out in Maternity. • Friends and Family responses remain static – Further focussed work to be carried out including in the AED. • Approval of the Patient Experience Strategy – Staff empowerment will be discussed as part of the strategy with work undertaken around kindness and values. The Improvement Academy tool will empower ward teams to engage with patients and carers. • PALS have seen an increase in numbers possibly due to further recent training provided around complaint handling. • Quality improvement work in complaints recognised and lessons being learned. • Staff empowerment will be discussed as part of the strategy. The report was noted by the Committee.	
Q.11.18.22	**Freedom to Speak Up (FTSU) Quarter 2 Report** SS noted the key points of this quarterly report. • Six concerns raised and under investigation through the FTSU route in Quarter 2, one concerning patient safety and the other concerning values. • The National Guardian's Office (NGO) is working with the CQC to support its development of the inspection and assessment process. • A National Guardian FTSU review of the handling of speaking up cases by the NGO at Nottinghamshire Healthcare NHS FT and the FT's FTSU action plan was noted. The report was noted by the Committee.	
Q.11.18.23	**Care Quality Commission (CQC) Compliance Action Plan** TC provided an update to the Committee on the progress of the action plan to date. The paper will be presented to the January Board of Directors' meeting. The status and comments were noted for each objective and the following highlighted: • Appraisal rates. • Mandatory training – Ward level compliance is required to ensure this is being thoroughly managed. • Consultant Respiratory cover over the weekend – TC will meet with the Chief Executive in order mitigations can be strengthened. • Maternity actions demonstrated good compliance. • Mock inspections are almost completed throughout the FT. Any actions required are being addressed. The Divisions have taken responsibility for 'should dos' and reports will be provided. • A cost centre has been set up for low cost work required. The Committee decided that it was assured that the appropriate systems and governance is in place to effectively manage the compliance action plan which was developed following the CQC inspections in 2018.	
Q.11.18.24	**Any Other Business** There was no other business.	

No.	Agenda Item	Action
Q.11.18.25	**Matters to share with other Committees** Workforce Committee: • Transfer of responsibility relating to assurance for Mandatory Training to be passed to the Workforce Committee. • New Starter Training – Report requested by the Quality Committee. • Legislative Programme for Regulation/Quality Impact Assessment for all new roles – FT's position.	
Q.11.18.26	**Corporate Risk Register** There were no issues to escalate to the Corporate Risk Register.	
Q.11.18.27	**Matters to Escalate to the Board of Directors** There were no matters to escalate to the Board of Directors.	
Q.11.18.28	**Item for Corporate Communications** There were no issues for Corporate communication.	
Q.11.18.29	**Agenda items for the meeting on 12 December 2018** The agenda was discussed and drafted for the meeting on 12 December 2018.	
Q.11.18.30	**Date and time of next meeting** Wednesday 12 December 2018, 9.30 am to 10.30 am, Conference Room, Field House, Bradford Royal Infirmary.	

Bradford Teaching Hospitals NHS Foundation Trust

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

Date of Meeting	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
28.03.18	Q.3.18.5	**(NICE Guidance on Rheumatoid Arthritis: Compliance and Issues) Triangulation of Data.** 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	12/12/18	Will be progressed by the new Trust Secretary. Timescale to be confirmed. 27/06/18: Deferred to November 2018 following October Board development day. 28/11/18: Topic to be considered for inclusion at February 2019 Board Development Session. **12/12/18: Clarity requested from Committee on what is required and if this should be picked up under action Q.9.18.23 - 'Big data' Understanding externally reviewed data.**
25.07.18	Q.7.18.5	**Focus on: Stroke Management and Care** A combined Airedale/Bradford report will be submitted to the September Quality Committee.	Medical Director	12/12/18	26.09.18: BG has requested that this is deferred to the Quality Committee scheduled for 28 November 2018 and this was agreed. 31/10/18: BG proposed the next report on Stroke will describe the continual progress being made by the FT, alongside a report on what the Stroke Collaboration with Airedale is doing in relation to quality. BG will also take a report to the Partnership Committee on the collaboration piece and the learning

Date of Meeting	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
					from that collaboration as part of the Airedale/Bradford Collaboration. The Committee agreed the report would be deferred until the December meeting when the SSNAP information will be included.
26.09.18	Q.9.18.6	**Quality Committee Dashboard** The Committee was not assured by the data presented regarding readmissions. The Quality Committee will ask the Finance and Performance Committee to review.	Head of Corporate Governance	12/12/18	31/10/18: Finance and Performance Committee asked to review the data around readmissions. Under review with Chief Operating Officer and action ongoing for Quality Committee. Post-meeting note: Finance and Performance Committee to receive report on 28/11/18. 28/11/1018: CCO advised that this would be undertaken as part of the planned 'deep dives' at which point the position would be reported back to the Quality Committee (in February 2019) following presentation of information to Finance and Performance Committee in January 2019.
31.10.18	Q.10.18.13	**Patient Safety and Health and Safety Management and Compliance Incident Report (Quarter 2 2018/19)** Regarding Regulation 28 and 29 from H M Coroner a response will be submitted within 56 days to H M Coroner, a copy of which will be presented to this Committee.	Director of Governance and Corporate Affairs	12/12/18	12/12/18: Action to be deferred to January 2019 - Due to the abridged Committee meeting in December. However, the Committee is asked to note that the response has been submitted to HM Coroner as required.

Date of Meeting	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
28.11.18	Q.11.18.8	**(Quality Committee Dashboard) RAG rating Commentary** Serious Incidents – TC will discuss the RAG rating commentary with John Holden, Director of Strategy and Integration.	Director of Governance and Corporate Affairs	12/12/18	TC has discussed with the Director of Strategy and Integration. Action completed.
28.11.18	Q.11.18.13	**(Serious Incident Report) Thematic analysis: Never Events** Concerning the trending around Never Events, a thematic analysis will be submitted to the December meeting by TC.	Director of Governance and Corporate Affairs	12/12/18	Item included on the agenda. Action concluded.
28.11.18	Q.11.18.13	**(Serious Incident Report) Trending in relation to Never Events** Concerning the trending around Never Events, a full discussion will be held at the Patient Safety Committee.	Director of Governance and Corporate Affairs	12/12/18	To be discussed at the Patient Safety Committee on 07.12.18. Action concluded.
28.11.18	Q.11.18.13	**(Serious Incident Report): Physician Associates** LS noted Physician Associates are now on the legislative programme for regulation and work under their medical dependent clinicians. This issue will be discussed at the Workforce Committee in relation to the FT's position and Quality Impact Assessments being undertaken for all new roles.	Director of Governance and Corporate Affairs	30/01/19	Workforce Committee Chair and Lead Executive advised of action. To be considered at Workforce Committee meeting on 30 January 2018.
28.11.18	Q.11.18.6	**Board Assurance Framework: Mandatory Training** The Committee agreed the transfer of responsibility of assurance associated with mandatory training be passed to the Workforce Committee with discussion at the Quality Committee by exception.	Chief Digital Information Officer	30/01/19	The dashboard to be updated to ensure mandatory training is presented in both the Quality Committee and Workforce Committee dashboards.
28.03.18	Q.3.18.15	**Briefing Paper: Trust Research Committee Update – March 2018** Bradford Institute for Health Research needs to	Medical Director	30/01/19	25/04/18: BG – Timescale adjusted to align to when the next report is due.

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		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.			
26.09.18	Q.9.18.23	**'Big data' – understanding externally reviewed data** BG will submit recommendations on how data will be viewed, understood and measured against. The document will be discussed at the Executive Director Time Out on 27 September 2018 and a further update will be provided by TC in January 2019.	Director of Governance and Corporate Affairs	30/01/19	
31.10.18	Q.10.18.14	**Security Management Standards for Providers** The Committee agreed it would be useful for the report to be submitted to the December Health and Safety Committee for discussion, and advice will be provided back to the Quality Committee as to how this may be progressed.	Director of Governance and Corporate Affairs	30/01/19	TC to discuss at Health and Safety Committee on 11/12/18.
28.11.18	Q.11.18.8	**(Quality Committee Dashboard) Catheters and Urinary Tract Infections** An exception report on Catheters and Urinary Tract Infections to be brought to the January meeting.	Chief Nurse	30/01/19	
28.11.18	Q.11.18.8	**Quality Committee Dashboard** An exception report on pressure ulcers to be brought to the February meeting.	Chief Nurse	27/02/19	
28.11.18	Q.11.18.8	**Quality Committee Dashboard** New Starter Training – The target is 100%, the Quality Committee will ask the Workforce Committee to advise if this has been attained.	Director of Governance and Corporate Affairs	27/02/19	Workforce Committee advised of the request from the Quality Committee.

Date of Meeting	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
26.09.18	Q.9.18.13	**Nurse Staffing Data Publication August 2018** LS agreed to share a paper regarding Physician Associates, once published, with BG as to their requirements on qualification.	Professor Laura Stroud	26/06/19	28.11.18: LS will now share the paper with BG regarding the introduction of Physician Associates into the workforce. The Committee noted the paper will not be published until June 2019.
29.08.18	Q.8.18.16	**Palliative Care Annual Report** KD agreed to include in the next report the number of patients who die on the ward, but not in a side ward.	Chief Nurse	28/08/19	