



**QUALITY COMMITTEE  
MINUTES, ACTIONS & DECISIONS**

<b>Date:</b>	Wednesday 30 January 2019	<b>Time:</b>	14:00 to 16:45
<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>- Ms Karen Dawber, Chief Nurse (KD)</li> <li>- Ms Cindy Fedell, Chief Digital and Information Officer (CF)</li> <li>- Dr Bryan Gill, Chief Medical Officer (BG)</li> </ul>		
<b>In Attendance:</b>	<ul style="list-style-type: none"> <li>- Dr Tanya Claridge, Director of Governance and Corporate Affairs (TC) via teleconference</li> <li>- Mrs Susan Franklin, Associate Chief Nurse for Quality Improvement (SF) for agenda item Q.1.19.12</li> <li>- Ms Helen Fearnley, Lead Tissue Viability Advanced Nurse Practitioner (HF) for agenda item Q.1.19.12</li> <li>- Dr LeeAnne Elliott, Deputy Chief Medical Officer (LAE) for agenda items Q.1.19.13 and Q.1.19.19</li> <li>- Juliet Kitching (Minute taker)</li> </ul>		
<b>Observer</b>	<ul style="list-style-type: none"> <li>- Mr Phil Wright, Consultant Orthopaedic Surgeon</li> </ul>		

No.	Agenda Item	Action
<b>Q.1.19.1</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.1.19.2</b>	<p><b>Declaration of Interests</b></p> <p>There were no declarations of interest.</p>	
<b>Q.1.19.3</b>	<p><b>Minutes and Actions of the Quality Committee meeting held on 12 December 2018</b></p> <p>The minutes of the last meeting were approved as an accurate record.</p>	
<b>Q.1.19.4</b>	<p><b>Matters Arising</b></p> <p>The Committee noted that the following actions had been concluded:</p> <ul style="list-style-type: none"> <li>- Q.12.18.21 (12.12.18) – Date and time of next meeting.</li> <li>- Q.10.18.13 (31.10.18) – Patient Safety and Health and Safety Management and Compliance Incident Report (Quarter 2 2018/10).</li> <li>- Q.11.18.13 (28.11.18) – (Serious Incident Report): Physician Associates.</li> <li>- Q.11.18.6 (28.11.19) – Board Assurance Framework: Mandatory Training.</li> <li>- Q.11.18.8 (28.11.18) – (Quality Committee Dashboard) Catheters and Urinary Tract Infections.</li> <li>- Q.11.18.8 (28.11.18) – Quality Committee Dashboard.</li> </ul>	

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Q.1.19.5	<b>Matters Arising from the Board of Directors and other Board Committees</b> There were no matters to report.	
Q.1.19.6	<b>Matters Escalated from Sub-Committees</b> LS reminded the Committee of the Sub-Committees of the Quality Committee: <ul style="list-style-type: none"> <li>• Children and Young People's Board.</li> <li>• Mortality Sub-Committee.</li> <li>• Integrated Safeguarding Committee.</li> <li>• Clinical Audit and Effectiveness Committee.</li> <li>• Information Governance Committee.</li> <li>• Patient Safety Committee.</li> <li>• Patients First Committee.</li> </ul> There were no issues of note from the above Committees.	
Q.1.19.7	<b>Implications of new Committee Terms of Reference</b> TC noted the Committee is operating to new Terms of Reference with a number of implications. The Terms of Reference were approved to be revisited in six months' time to ensure alignment.	Director of Governance and Corporate Affairs
Q.1.19.8	<b>Strategic Risks relevant to the Committee</b> TC discussed the assurance related to the strategic risks relevant to this Committee. The Committee were asked to note the current mitigation where assurance is provided to risks via the Integrated Governance and Risk Committee. Any items, if graded over 12 are discussed within the meeting, listed on the Strategic Risk Register and managed and assured directly by the appropriate Executive Director.	
Q.1.19.9	<b>Board Assurance Framework (BAF) and Strategic Risks relevant to the Committee</b> TC presented the key controls which have been aligned to the Quality Plan following earlier discussions with BG and KD. Exception reports from sub-committees continue to be received.  The clear and positive report was noted by the Committee.	
Q.1.19.10	<b>Quality Dashboard</b> The following were noted from the Quality Dashboard: <ul style="list-style-type: none"> <li>• Positive report on mortality.</li> <li>• Positive report on Venous Thromboembolism (VTE).</li> <li>• Serious Incident (SI) reporting - The rate has remained relatively constant.</li> <li>• The importance of the new dashboard was noted and the context discussed in terms of its use alongside the 'focus on' sessions.</li> <li>• Catheters and Urinary Tract Infection - A report will be discussed under agenda item Q.1.19.14.</li> <li>• Sepsis – The December position was noted with weekly results showing improvement following increased clinical engagement.</li> <li>• Antibiotics within an hour – Work continues within this area. BG reported that a report showed the national average is between 50 and 60% and the Committee agreed it would be useful to reflect national averages if information is available on a routine basis.</li> </ul>	

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	<ul style="list-style-type: none"> <li>Complaints data – The number of complaints within the system are reducing and the improvement was acknowledged. Comparative data for 2017/18 has been identified with regards complaints. In April 2018 there were 220 complaints in the system compared with 74 as of 29 January 2019. The complaints closed information has been underreported over the last two months. An update will be provided to the February meeting.</li> </ul> <p>The report was noted by the Committee.</p>	Chief Nurse
Q.1.19.11	<b>Quality Oversight System Report</b> The report was received by the Committee.	
Q.1.19.12	<b>Focus on: Pressure Ulcers</b>  Pressure ulcers - QC Jan 2019.pptx <p>KD introduced SF and HF who were welcomed to the meeting to discuss the work and the significant improvements made over the last two to three years.</p> <ul style="list-style-type: none"> <li>Category 2+ pressure ulcers, avoidable and non-avoidable published as recommended by NHS Improvement.</li> <li>Significant improvement in the number of Category 3 pressure ulcers.</li> <li>The last Category 4 pressure ulcer was December 2015.</li> <li>Omissions in care considered for each case.</li> <li>Increase in team members, leading to increased vigilance of staff on the wards, resulting in increased reporting since 2016.</li> <li>Decrease in the number of pressure ulcers reported during the introduction of the Electronic Patient Record (EPR) which then increased as staff became more familiar with the system.</li> <li>Downward trend of SI pressure ulcers.</li> <li>Downward trend against peers and national statistics (improved position).</li> <li>Causes discussed for pressure ulcers in patients, eg medication.</li> <li>Timely referrals leading to timely treatment.</li> <li>Positive commitment of the team.</li> <li>Work undertaken with NHS Improvement from Spring 2018 on the national pressure ulcer collaborative.</li> <li>Introduction of safety huddles as part of the collaboration.</li> <li>Improvement work: Plaster room, policy updates, moisture associated skin damage and minor updates to EPR.</li> <li>Next steps: Pressure ulcer collaborative development, continuing training, education and practice development in Maternity, Theatre and competencies, continuing multi-disciplinary referrals. The team will record the categories of healing success rates.</li> </ul> <p>The Committee thanked HF for the informative presentation.</p>	
Q.1.19.13	<b>Focus on: Safer Procedures</b>  Q.1.19.13 - Safer Procedures Collabora <p>LAE was welcomed to the meeting to present the above.</p>	

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	<p>Over numerous years there has been a heavy focus on safer procedures in the FT's theatres regarding checking processes which has now broadened to outwith the theatre environment. LAE discussed the work ensuring this focus outside of the theatre environment and described the National Safety Standards for Invasive procedures published in 2015 relating to invasive procedures performed in any location.</p> <p>LAE discussed the significant work underway across the organisation to reduce the risk where there is the potential for a Never Event, regardless of where the procedure is performed. This does not relate to procedures whereby a single person is undertaking a procedure in a ward environment.</p> <ul style="list-style-type: none"> <li>• Safer Surgery Group formed.</li> <li>• Involvement of the Improvement Academy and NHS Quest.</li> <li>• Updated Policy and reviewed documentation.</li> <li>• Production of the BRADSIPPS handbook.</li> <li>• 99 to 100% compliance on the theatre checklists noted in regular monthly audits.</li> <li>• Team training and engagement.</li> <li>• Outside of theatre work ongoing.</li> <li>• Work continues to devise checklists in all areas where invasive procedures are performed.</li> <li>• Commencement of the quality improvement collaborative using IHI methodology.</li> <li>• Re-profiling of the Safer Procedures Group to include fifteen different departments and theatres.</li> <li>• Audit and assurance work.</li> <li>• Update of the work to be provided to the Quality Committee in April 2019.</li> </ul> <p>BG reported as part of the Care Quality Commission (CQC) preparation process it is anticipated every area, where applicable, has an appropriate checklist and audits will have been undertaken by the end of March.</p> <p>From the walkrounds undertaken initial findings have noted the checklists have proved a useful resource. Measures and display of outputs will be considered.</p> <p>The Committee noted the assurances provided.</p>	<p>Chief Medical Officer</p>
<p><b>Q.1.19.14</b></p>	<p><b>Focus on: Infection Prevention and Control Exception Report</b></p> <p>KD discussed the report noting recent Safety Thermometer data relating to an increase in catheter associated Urinary Tract Infections. The report provided explanation of the safety thermometer data collation process, analysis and elements of the data collation which requires improvement. Results showed staff were not basing findings on the pure definition of a Urinary Tract Infection but on a positive urine dipstick. Actions and the work plan were noted.</p> <p>Checks are now in place and following further education a nurse-led project through the Infection Prevention and Control Committee will be carried out monitoring the use of urinary catheters. A report will be submitted in July 2019. KD has discussed with Kay Pagan, Assistant Chief Nurse for Informatics, assistance with audits via EPR to monitor nursing practice and care plans.</p> <p>BG hoped infra-graphics would be developed by each specialty, describing</p>	<p>Chief Nurse</p>

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	<p>innovations and their successes. KD noted a recent meeting held with Ruth Girdham, Head of School of Nursing and Healthcare Leadership at the University of Bradford, where it had been agreed nurses undertaking research projects in year 3, will be provided with topics of interest by the FT with this work showcased.</p> <p>A progress report will follow in the Quarter 2 Infection, Prevention and Control report 2019.</p> <p>The report and recommendations were noted by the Committee.</p>	Chief Nurse
<b>Q.1.19.15</b>	<p><b>Serious Incident (SI) Report</b></p> <p>TC presented the report noting three new SIs reported by the FT during December 2018, the failure to monitor a long standing wound, a safeguarding incident, the report for which will be undertaken by the provider, and a Grade 3 pressure ulcer where omissions in care had been identified. An investigation into an SI was concluded in December 2018 relating to a fall where omissions in care had been identified. KD reported lessons have been learned and actions taken with the incident having driven improved behaviour and culture on the ward.</p> <p>The incidents are being managed through appropriate processes and immediate actions have been taken.</p> <p>A request has been made to de-log an SI reported during December 2018. The challenges around this incident and the criteria of the SI were discussed.</p> <p>TC noted the revised SI Policy will ensure appropriate peer support for staff involved in an incident.</p> <p>The Committee were assured in relation to the recommendations and actions identified within the report.</p>	
<b>Q.1.19.16</b>	<p><b>Quarterly Incident Report</b></p> <p>TC discussed the monthly report, which will be shared externally with commissioners which profiles the totality of patient safety and health and safety management and compliance incidents, themes and trends, actions and learning. The appendices 1 to 4 of the report were discussed and the following highlighted:</p> <ul style="list-style-type: none"> <li>• Areas of additional focus and scrutiny continue to be the Maternity Service, haematology and theatres.</li> <li>• Medication incidents are monitored through the Medicines Safety Group.</li> <li>• Medicines management and governance will be subject to future review.</li> <li>• Work to be undertaken around care and treatment categories in relation to patient discharge incidents.</li> <li>• Compared to the national average performance in relation to claims management is good.</li> <li>• Positive and rigorous processes were noted around the effectiveness and assurance of actions from SIs and internal investigations.</li> <li>• The Committee and Board members have been previously sited concerning recent media interest around a breach in Duty of Candour. This area will be re-audited.</li> <li>• Significant assurance provided to the FT from the Audit Yorkshire audit</li> </ul>	

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	<p>received around the Risk Management Strategy.</p> <ul style="list-style-type: none"> <li>The forthcoming challenges relating to the restructure were noted. Deloitte have been engaged to undertake some coaching to support the development of enhanced governance.</li> </ul> <p>The detailed report was noted and assurance in relation to the recommendations made within the report was agreed.</p>	
Q.1.19.17	<p><b>Regulation 28 response: Information about Venous Thromboembolism (VTE) for Patients</b></p> <p>TC discussed the assurance in relation to the FT's response to the Regulation report received in respect of an inquest. The notice related to information provided to patients on discharge from hospital that they may be at risk of VTE, following surgery after sustaining a trauma.</p> <p>The FT had reviewed current practice across all at risk patient groups. Written information provided to patients was subsequently strengthened to improve compliance with NICE Guidance. The leaflet will be routinely provided to patients. Accessible information is currently under review for example EPR and apps.</p> <p>The Committee noted the report and were assured in relation to the response of the Regulation 28 notice.</p>	
Q.1.19.18	<p><b>Nurse Staffing Data Publication Reports – November 2018 and December 2018</b></p> <p>KD noted the documents had been discussed in detail at the earlier Workforce Committee and the following highlighted:</p> <ul style="list-style-type: none"> <li>Fewer falls with harm.</li> <li>The two falls documented with moderate harm were incorrectly graded as moderate (should be low), resulting in there being no falls with moderate or severe harm in the month of December 2018 and for over a year within the FT.</li> <li>Staffing levels remain consistent at around 90% fill rate for registered and Healthcare Assistants around 100%.</li> <li>Maternity wards show an 89% fill rate for midwives and staff nurses and a red fill rate for Health Care Assistants, due to short- and long-term sickness absence and maternity leave.</li> <li>Maternity continues to have the best retention and staffing rates.</li> <li>Red flag data will be processed for Maternity over Quarter 4.</li> </ul> <p>The report was noted by the Committee.</p>	
Q.1.19.19	<p><b>Update and Assurance on the work of the Patient Safety Sub-Committee</b></p> <p>LAE provide assurance to the Quality Committee on the purpose of the Patient Safety Sub-Committee and the following were noted:</p> <ul style="list-style-type: none"> <li>Successful and productive meeting and good attendance and engagement.</li> <li>Meetings recently successfully refocused.</li> <li>Areas of concern are considered and improved.</li> <li>Challenging areas around the Safer Procedure Group and the Thrombosis Group were noted along with recent progress in these areas.</li> <li>Engagement with the Division over safety issues.</li> </ul>	



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	LS noted the informative report and the achievements were noted. The report was accepted by the Committee.	
Q.1.19.20 Q.1.19.21	<p><b>Information Governance (IG) Report</b>  <b>Senior Information Officer Report (SIRO)</b>            CF discussed the reports and highlighted there had been no new incidents, the new toolkit is focused on Cyber security and IG training requires improvement.</p> <p>Two external reviews requested by the FT on Cyber security have just been undertaken that will be reviewed and any related plans put in place.</p> <p>These reports were noted by the Committee.</p>	
Q.1.19.22	<p><b>Learning from Deaths Quarterly Report</b>            BG highlighted the following:</p> <ul style="list-style-type: none"> <li>• Mortality rates and the further work being undertaken in this area.</li> <li>• NEWS2, an expansion of early warning scores, including additional measures and linked to EPR and the Command Centre.</li> <li>• Medical Examiner – National guidance is expected. Consideration being given to implementation of this post within the FT from April and work within specialties in relation to death reviews underway.</li> </ul> <p>TC noted mortality will move to the effectiveness agenda from Quality Improvement.</p> <p>An options paper will be submitted to the Executive Management Team on the estimated impact of implementation of the medical examiner role.</p> <p>The positive report was noted by the Committee.</p>	Chief Medical Officer
Q.1.19.23	<p><b>Patient First Sub-Committee Annual Report</b>            KD reported the Committee had met on ten occasions over the last year and two patient representatives are members of the Committee. The Terms of Reference are under review following issues of quoracy. The main risk managed through the Committee concerns complaints. Over the last year the number of complaints has reduced from 220 to less than 80. A complaints review group was set up to oversee the process and report to the sub-committee.</p> <p>A 'Patients who pose a risk' working group has been set up reporting into this sub-committee.</p> <p>KD noted the achievements:</p> <ul style="list-style-type: none"> <li>• Local surveys and Patient Reporting and Action for a Safe Environment audits have been widened out to patient areas.</li> <li>• The Patient Experience Team has been rebranded.</li> <li>• Positive assurance has been received regarding children on adults' wards.</li> <li>• Improved results of the Cancer Survey.</li> <li>• Disabled Go is now live on the FT's website.</li> <li>• Achievement of Neonatal Unit (Level 3) to achieve baby friendly status.</li> <li>• National maternity neonatal collaborate work underway in Maternity services.</li> </ul>	

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	<ul style="list-style-type: none"> <li>• Use of patient stories as part of divisional training.</li> <li>• Dementia patients in elderly care – Activity co-ordinators visiting monthly.</li> <li>• Signage for disabled parking around the FT site.</li> <li>• Quality Improvement (QI) collaboration.</li> <li>• Communication standards.</li> </ul> <p>The comprehensive and positive report was noted by the Committee.</p>	
Q.1.19.24	<p><b>Bradford Accreditation Scheme</b></p> <p>KD discussed how the current Bradford Accreditation Scheme could be developed and improved using existing resources to demonstrate the ongoing performance of a ward or department and support continuous quality improvement throughout the organisation. This will ensure QI is embedded against a bespoke set of ward and departmental metrics and the proposed changes were discussed including electronic data input and unannounced inspections.</p> <p>The Committee agreed to this way forward and approved the proposal.</p>	
Q.1.19.25	<p><b>Leadership Walkround Quarterly Update</b></p> <p>BG discussed the positive quarterly report noting the revised format of the walkround engagement.</p> <p>The content and assurance of progress to date was noted by the Committee.</p>	
Q.1.19.26	<p><b>ProgRESS Report</b></p> <p>TC noted the CQC action plan had been discussed at the recent Board of Directors' meeting. Work continues focussing on CQC preparation and a number of mock inspections have been undertaken.</p> <p>The Committee credited TC and her team for the work to date and TC noted support and engagement from staff with regards to the mock inspections.</p>	
Q.1.19.27	<p><b>Children and Young People's Board Report</b></p> <p>BG discussed the Children and Young People's annual report noting three meetings had taken place in the last twelve months and not two as documented in the report.</p> <p>BG highlighted:</p> <ul style="list-style-type: none"> <li>• Reduction in children being transferred from BTH to paediatric ICU in Leeds by 30%.</li> <li>• Improvement required in the collection of stabilisation data.</li> </ul> <p>BG suggested inviting the team to present on children's services at a future Quality Committee.</p> <p>The report was noted by the Committee.</p>	
Q.1.19.28	<p><b>Maternity Services Quarter 3 Report</b></p> <p>KD presented the report on behalf of the Chief Operating Officer noting huge service improvements.</p>	



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	<p>The key issues were discussed:</p> <ul style="list-style-type: none"> <li>• Significant improvements in the midwifery staffing position with 23 newly qualified midwives having commenced in October with an extended period of induction.</li> <li>• Opening of the Maternity Assessment Centre on 11 November 2018.</li> <li>• One to one care during labour has increased from 60% to between 72 and 75%.</li> <li>• Significant improvement in staffing in obstetric theatres and theatre staffing cover now in place.</li> <li>• Recruitment of a third substantive Matron for Midwifery and Gynaecology.</li> <li>• Appointment of a Clinical Risk and Governance Lead Midwife.</li> <li>• Appointment of a Specialist Midwife for Infant feeding who will support the Maternity Unit to regain Baby Friendly accreditation status.</li> <li>• Appointment made to a Consultant Obstetrician post.</li> <li>• Clinical outcomes data was discussed.</li> <li>• Yorkshire and Humber Maternity Dashboard, Quarter 1 2018/19.</li> <li>• SI underway concerning a maternal death reported of a patient who suffered a pulmonary embolus.</li> <li>• Criteria noted for the Health and Safety Investigation Branch taking over investigations from 3 December 2018.</li> </ul> <p>Key challenges were noted:</p> <ul style="list-style-type: none"> <li>• Reasons for suspension of service.</li> <li>• Risk posed by Obstetric Theatre Ventilation – A report is expected to the Infection, Prevention and Control Committee in February with an update to be provided to the February Quality Committee.</li> <li>• Complaints, themes, priorities and good news stories.</li> </ul> <p>BG noted an external professor visited the FT in January to meet the team and will continue to revisit each quarter for the next twelve months to support the team.</p> <p>The dashboard should reflect the FT being more in line with the West Yorkshire/national average.</p> <p>BG noted the assurance, through mitigations in place and noted the issues in the report will be common throughout other Maternity Units in the country.</p> <p>LS noted the report and referenced the previous presentations by the team which provided assurance.</p>	Chief Nurse
Q.1.19.29	<p><b>Any Other Business</b></p> <p>There was no other business.</p>	
Q.1.19.30	<p><b>Matters to share with other Committees</b></p> <p>There were no items to share with other Committees.</p>	
Q.1.19.31	<p><b>Matters to escalate to the Strategic Risk Register</b></p> <p>There were no issues to escalate to the Strategic Risk Register.</p>	
Q.1.19.32	<p><b>Matters to Escalate to the Board of Directors</b></p>	

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	There were no matters to escalate to the Board of Directors.	
<b>Q.1.19.33</b>	<b>Item for Corporate Communications</b> There were no items for Corporate communication.	
<b>Q.1.19.34</b>	<b>Agenda items for meeting scheduled 27 February 2019</b> The draft agenda for the February meeting was noted.	
<b>Q.1.19.35</b>	<b>Date and time of next meeting</b> Wednesday 27 February 2019, 14.00-16.00, Conference Room, Field House, Bradford Royal Infirmary.	



**BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST**  
**ACTIONS FROM QUALITY COMMITTEE – 30 January 2019**

Date of Meeting	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
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.	Chief Medical Officer (Medical Director)	27/02/19	25/04/18: BG – Timescale adjusted to align to when the next report is due. 30/01/19: Formal paper due at the end of February 2019. Item on the agenda. <u>Action concluded.</u>
26.09.18	Q.9.18.23	<b>‘Big data’ – understanding externally reviewed data</b> 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 January 2019.	Chief Medical Officer (Medical Director)	27/02/19	30/01/19: The Committee recognised confusion around this action. The inclusion of all available sources of data within dashboards was discussed, eg reviewing available data and subsequent presentation. Conversations are taking place with the CCG, NHSI and the CQC re the development of an agreed single data set for Maternity in order all necessary available information will provide assurance from the organisations and will align regarding presentation of information. An update will be provided in February on the outcome of discussions. A comprehensive holistic, robust dataset will be devised and tested out with Maternity during 2019. <u>BG to provide verbal update on 27.02.19.</u>

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31.10.18	Q.10.18.14	<b>Security Management Standards for Providers</b> 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.	Chief Nurse	27/02/19	TC to discuss at Health and Safety Committee on 11/12/18. 12/12/18: TC reported this was discussed at the Health and Safety Committee the previous day and work is being undertaken. KD to review the policy prior to 30/01/19. 30/01/19: TC reported a new standard has been introduced around training of staff in patients who have clinically challenging behaviour and KD and TC will meet to discuss
28.11.18	Q.11.18.8	<b>Quality Committee Dashboard</b> 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	
12.12.18	Q.12.18.16	<b>Any Other Business</b> BG reported that the Education Plan is due to be signed off in the new year and would need to be presented to a number of Committees and asked whether it would be appropriate to do this at a future Board Development session. TC said it would be useful to design a Board Development day to focus on this particular strategic objective and linked to education/quality of care/research and Wolfson.	Director of Governance and Corporate Affairs	27/02/19	27/02/19: Presented to the Board Development session on 07/02/19. <u>Action concluded.</u>
30.01.19	Q.1.19.10	<b>Quality Dashboard</b> Complaints data – The complaints closed information has been underreported over the last two months. An update will be provided to the February meeting.	Chief Nurse	27/02/19	12/02/19: Will be noted on the dashboard. <u>Action concluded.</u>

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30.01.19	Q.1.19.22	<b>Learning from Deaths Quarterly Report</b> An options paper will be submitted to the Executive Management Team on the estimated impact of implementation of the medical examiner role.	Chief Medical Officer	27/02/19	27/02/19: There will be a presentation to the Clinical Audit and Effectiveness Committee and then to the Executive Management Team meeting. <u>Action concluded.</u>
30.01.19	Q.1.19.28	<b>Maternity Services Quarter 3 Report</b> Risk posed by Obstetric Theatre Ventilation – A report is expected to the Infection, Prevention and Control Committee in February with an update to be provided to the February Quality Committee.	Chief Nurse	27/02/19	27/02/19: The update on Ventilation will be included in next month's Infection Prevention and Control report.
30.01.19	Q.1.19.13	<b>Focus on: Safer Procedures</b> An updated of the work to be provided to the Quality Committee in April 2019.	Chief Medical Officer	24/04/19	
26.09.18	Q.9.18.13	<b>Nurse Staffing Data Publication August 2018</b> 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. 27/02/19: Paper from LS shared with BG and KD. <u>Action concluded.</u>
28.03.18	Q.3.18.5	<b>(NICE Guidance on Rheumatoid Arthritis: Compliance and Issues) Triangulation of Data.</b> A recommendation should be given for the Chairman	Director of Governance and Corporate Affairs	26/06/19	Will be progressed by the new Trust Secretary. Timescale to be confirmed. 27/06/18: Deferred to

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		to include triangulation of data (linked with presentations) in a future Board Development Session.			<p>November 2018 following October Board development day. 28/11/18: Topic to be considered for inclusion at February 2019 Board Development Session.</p> <p>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. TC explained this is related to pre-cursor data and triangulation of data across the Trust and is not just for Rheumatoid Arthritis. BG explained this is linked to measuring outcomes in a consistent way with the CCG and needs to be developed from January 2019 for a duration of 6 months preferably starting with Maternity. Update to be provided in 6 months.</p>
30.01.19	Q.1.19.7	<b>Implications of new Committee Terms of Reference</b> The Terms of Reference were approved to be revisited in six months' time to ensure alignment.	Director of Governance and Corporate Affairs	31/07/19	
30.01.19	Q.1.19.14	<b>Focus on: Infection Prevention and Control Exception Report</b> Checks are now in place and following further education a nurse-led project through the Infection Prevention and Control Committee will be carried out monitoring the use of urinary catheters. A report will	Chief Nurse	31/07/19	



Date of Meeting	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
		be submitted in July 2019.			
30.01.19	Q.1.19.14	<b>Focus on: Infection Prevention and Control Exception Report</b> A progress report will follow in the Quarter 2 Infection, Prevention and Control report 2019.	Chief Nurse	31/07/19	
29.08.18	Q.8.18.16	<b>Palliative Care Annual Report</b> 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	