Bradford Teaching Hospitals
NHS Foundation Trust

QUALITY COMMITTEE
MINUTES, ACTIONS & DECISIONS

Date:	Wednesday 27 March 2019	**Time:**	14:00 to 16:00
Venue:	Conference Room, Field House, Bradford Royal Infirmary	**Chair:**	Professor Laura Stroud Non-Executive Director
Present:	**Non-Executive Directors:** - Professor Laura Stroud, Non-Executive Director (LS) - Mr Jon Prashar, Non-Executive Director (JP) **Executive Directors:** - Ms Karen Dawber, Chief Nurse (KD) - Dr Bryan Gill, Chief Medical Officer (BG) - Ms Cindy Fedell, Chief Digital and Information Officer (CF)		
In Attendance:	- Dr Tanya Claridge, Director of Governance and Corporate Affairs (TC) - Ms Sara Hollins, Head of Midwifery, Women's Services (SH), for agenda item Q.3.19.11 - Ms Tina Mori, Midwifery Matron (TM), for agenda item Q.3.19.11 - Juliet Kitching (Minute taker)		

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Q.3.19.1	**Apologies for Absence** - Ms Selina Ullah, Non-Executive Director (SU)	
Q.3.19.2	**Declaration of Interests** There were no declarations of interest.	
Q.3.19.3	**Minutes and Actions of the Quality Committee meeting held on 27 February 2019** The minutes of the last meeting were approved as a correct record.	
Q.3.19.4	**Matters Arising** The Committee noted that the following actions had been concluded: - Q.1.19.28 (30.01.19) – Maternity Services Quarter 3 Report. - Q.2.19.5 (27.02.19) – Strategic Risks relevant to the Committee. - Q.2.19.11 (27.02.19) – Clinical Effectiveness Quarter 3 Report 2018/19. - Q.2.19.14 (27.02.19) – Nurse Staffing Data Publication – January 2019. - Q.2.19.16 (27.02.19) – Patient Experience Quarter 3 Report.	
Q.3.19.5	**Matters Arising from the Board of Directors** • The Board of Directors delegated responsibility for the sign-off of the Information Governance toolkit to the Quality Committee. • The Board of Directors agreed to the Committee's formal review of the Board Assurance Framework in April 2019, looking at strategic controls and risks.	
Q.3.19.6	**Matters Escalated from Sub-Committees** LS reminded the Committee of the Sub-Committees of the Quality Committee: • Children and Young People's Board.	

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	• Mortality Sub-Committee. • Integrated Safeguarding Committee. • Clinical Audit and Effectiveness Committee. • Information Governance Committee. • Patient Safety Committee. • Patients First Committee. Readmissions - To be discussed by BG in agenda item Q.3.19.9. The specialties of Infectious Diseases and Dermatology had been discussed at the Workforce Committee on 27 March 2019. BG noted the forthcoming impacts on the Infectious Disease service, all aspects having been mitigated and actioned. Weekly meetings are being held with the team, there are currently no issues.	
Q.3.19.7	**Strategic Risks relevant to the Committee** The strategic risks were reviewed by the Committee in connection with controls, mitigation and assurance presented within the Board Assurance Framework and the Quality Committee dashboard to ensure that, where necessary, controls are in place and are being monitored for their effectiveness. BG noted over the last twelve to eighteen months there had been strengthened oversight across the services provided by the organisation, enabling the early identification of potential pockets of concern, highlighting in particular the work in understanding and integrating our data, data quality, the Going Digital strategy, national audits and the Model Hospital. This integration was described as being key as there is no single system available which would identify early warnings about oscillations in the quality of care being provided by a service. TC will present the Trust's revised Risk Management Strategy and a paper describing the Trust's Quality Management System which together will demonstrate a clear route of escalation to this Committee at the April meeting of this Committee. KD noted from her experience this organisation has most sophisticated systems of risk management she has worked with. The Committee noted the report.	Director of Governance and Corporate Affairs
Q.3.19.8	**Board Assurance Framework (BAF)** LS noted the strategic objectives within the BAF for which the Committee has responsibility to assure and advise the Board of Directors. The Committee will consider whether there are any changes to the levels of assurance indicated during the meeting and discuss in agenda item Q.3.19.27.	
Q.3.19.9	**Quality Dashboard** LS noted the document and the following issues were discussed. • VTE – Improvement trajectory is being maintained. • Falls with harm – The trajectory was noted. A commentary box is now	

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	included where the level of harm is indicated. There will be a full review of all indicators after April. • Pressure ulcers – No issues of concern. A number of episodes in February related to the Intensive Care Unit where any lapses of care were duly noted. • Sepsis – The funding for the sepsis nurse has been extended for a further year. • Complaints – The trajectory continues to improve despite senior staff vacancies within the team. • Readmissions – Readmissions have increased significantly post Electronic Patient Record (EPR) implementation. Two pieces of work are underway regarding admissions. The first looking at the number of attendances logged as readmissions, but were not against the readmission criteria, and secondly work to understand the attendances which were planned attendances to understand the type of readmission. CF and BG noted the Foundation Trust's (FT) data quality is improving with respect to the different components. A consistent approach to the way admissions are reported and data is produced for the Finance and Performance Committee is under consideration to assist benchmarking. • Risks not mitigated – A recent internal audit report in relation to the implementation of the Risk Management Strategy has resulted in a significant assurance rating. The Key Performance Indicators should only identify the risks not mitigated by the due date and as a result the metrics used to monitor the quality of governance in the FT are being reviewed. • Out of date policies – The focussed programme of work continues in order to improve the FT's position in relation to Trust-wide policies and their management. A target has been set of 100%. The report was noted by the Committee.	
Q.3.19.10	**Quality Oversight System Report** TC tabled the March 2019 report discussing illustrated effective processes for managing risks and issues, providing assurance to the Committee with background information and other governance summaries as required. TC discussed surveillance, understanding, managing and learning within the report, noting the identification of precursor incidents associated with delays in relation to correspondence for follow-up appointments in Cardiology and Cystoscopy which are being explored. TC and CF will consider areas where the quality of clinical documentation can be assured through the use of the precursor incident identification model. The report was accepted by the Committee.	
Q.3.19.11	**Focus on: Maternity Services Survey and Response**  Q.3.19.11 - Maternity Services Su SH and TM were welcomed, introduced to the Committee and presented the results of the now annual seventh national survey.	

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	At the February Quality Committee KD discussed the positive results from the Maternity survey, however, this was not considered to be reflected within the report. The following were noted: • 414 surveys despatched with a 29% response rate showing a slight increase on the previous year (the lower end of normal). 122 Trusts included, the survey was live births only. • Survey only sent out in English, recipients directed to a web page if another language was required. • The questions showing at least 5% improvement since the last survey were discussed. The FT scored in the top 20% of Trusts nationally over eight questions and in the bottom 20% for twelve questions, however, only two of the questions were statistically significant. • Overall results considered average. • Surveys allow no time for service improvements to be made as results are not published until January, with surveys despatched in February of the same year. • Comparisons between the 2017 and 2019 surveys will be made in the future. • Regional and local work underway in the unit includes obstetric theatre staffing and one to one care during labour. • Priority areas for improvement and improved communication. • Positive staff engagement. • The ward welcome pack will be updated to include advice on contraception and access to post-natal care. Following the successful and positive work within the unit, BG requested this data be carefully compiled and captured prior to the CQC formal assessment with dissemination of a copy or a summary of the presentation being sent to all departmental teams and to each Consultant. The Committee noted the survey confirmed the FT is delivering services in line with other units and is always striving to improve.	
Q.3.19.12	**Serious Incident (SI) Report** The Committee considered the paper which summarised the serious incident profile of the Trust for February 2019. Three SIs were declared in February 2019 regarding: • A patient who suffered a cardiac arrest in the X ray Department. • A patient who had two doses of a prescribed medication omitted. • An allegation of assault of a child by a Trust employee. No Never Events were declared in February 2019. Where appropriate, immediate and necessary actions have been put in place. Four SI investigations were concluded in February 2019: • A Never Event where there was a removal of the wrong tooth in a child undergoing surgery for several decayed teeth. Learning has been identified to ensure there is a 'time out' when there is a change of staff in theatre. • Misdiagnosis for a patient with a rare form of cancer. The investigation	

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	team was unable to identify any care or service delivery problems, diagnostic testing has evolved since this occurred in 2016. • Incorrect site injection of local anaesthetic into a toe. This was found to be an example of an inadvertent human error, secondary to a unique on the day change in the patient's care pathway. • Undiagnosed Breech. The investigation team was unable to identify any care or service delivery problems, there was no indication at any antenatal assessment that the patient had a breech presentation. The Committee was assured that the Trust has processes in place to identify, investigate and learn from serious incidents.	
Q.3.19.13	**Nurse Staffing Data Publication – February 2019** KD highlighted the key points in the report. February saw an increase in the number of incidents reported with eight out of twenty-five due to staff being transferred from other areas, none resulted in any patient harm. One completely unavoidable incident referred to a community hospital ward having only one registered nurse on the ward alone for approximately two hours nursing stable community patients. The report was noted by the Committee.	
Q.3.19.14	**Infection Prevention and Control Report** KD discussed the positive report. Outbreak of Carbapenemase-producing Enterobacteriaceae (CPE) – An increase in the number of related cases around Ward 8 had been noted since last October. A decision was taken following a further cluster of these cases to empty ward 8, deep clean and fog the ward. Any further cases will continue to be traced. No more than two linked cases have been seen. C difficile - The objective for the year has been set using the data from the previous twelve months. The FT objective for 2019/20 has been set at 30 cases. This is a reduction of 20 cases per year with a change to the case assignment definition so cases previously reported as community cases could now be assigned as hospital cases. A piece of work is underway to identify the current figures if the new definition was applied retrospectively. Ventilation in Maternity Theatres – Extensive discussions have ensued at all levels including the Integrated Governance and Risk Committee. The Infection Control team is currently working closely with Maternity services. Data is being collected on any cases undertaken in the theatres. BG noted, as the Deputy Lead for a national trial, the FT is one of thirty centres screening patients for MSSA pre- knee and hip surgery. The FT has not had a single wound infection or deep infection in over 300 cases. This is a credit to the outstanding team in the FT and the report was noted and approved by the Committee.	
Q.3.19.15	**Security Management Standards for Providers** TC informed the Committee the action plan is maintained and managed by the Health and Safety Committee. A Task and Finish group is reviewing the strategic risks. Areas of non-compliance around training have been identified	

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	both in relation to conflict resolution and restraint. These are being urgently addressed through the Task and Finish group. The report was noted by the Committee.	
Q.3.19.16 **Q.3.19.17**	**Information Governance (IG) Report** **Information Governance Toolkit** CF reported the monthly IG report has remained constant over the last few months. There have been no breaches. CF discussed the improved position on the data quality maturity table which is refreshed every six months resulting in the Trust being at a 'Defined' state with respect to data quality maturity. The Trust is fully compliant with the new Toolkit, renamed the Data Security and Protection Toolkit. The position was reviewed and signed off at the Information Governance Sub-Committee meeting on 14 March 2019. At that time the training position was not at 95% and was approved based on the high level of awareness already in place. However the Trust is now in excess of 95% and has met this target. The Board of Directors have delegated authority to the Quality Committee to sign off the submission due to the timing of the meeting in March 2019. The impressive report was noted by the Committee who acknowledged the amount and level of work required for the Trust to be compliant. The Committee approved the submission of the Data Security and Protection Toolkit on behalf of the Board of Directors. An acknowledgement will be sent to the team.	Director of Governance and Corporate Affairs
Q.3.19.18	**National Audit Care at End of Life** KD noted the results of the National Audit Care at End of Life survey had been discussed at the End of Life Care Operational meeting and the Patient First Committee. The full national benchmark results remain unpublished, however, on publication will be considered at the Clinical Effectiveness Committee.	
Q.3.19.19	**Update paper: Single Stroke Service Collaboration Project – March 2019** BG discussed the paper written for submission to the three different organisations namely Bradford Teaching Hospitals, Airedale and the Clinical Commissioning Group. BG discussed the positive report and referenced the following: • The significant progress and improvements made within both organisations to the Sentinal Stroke National Audit Programme (SSNAP). Agreement has been received from national SSNAP for a single SSNAP score to be reported for the Airedale/Bradford service at a national level. A commencement date will be agreed. • Discussions are underway to identify how this work can be used for collaborations around other services between Airedale and Bradford. • Patient engagement work. The report was commended and accepted by the Committee.	
Q.3.19.20	**Combined Learning Report** TC discussed the report providing a summary of the Trust-wide learning during	

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	Quarters 2 and 3 of 2018/19. The purpose of the report is to describe learning and learning outcomes, and these were presented in relation to the risk associated with the identified precursor event. Assurance examples of how learning was disseminated or actioned were noted. The report included a summary of a learning event held by the Quality Improvement Team and described the intranet site for learning. Learning issues around the workforce including stress and staffing via Schwartz rounds and people matters, were raised to be considered for inclusion by the learning hub.	
Q.3.19.21	**Clinical Services Strategy** TC discussed the Clinical Services Strategy 2017-2022 and the Quality Plan 2018/19, describing how clinical services consistent with the FT's vision are being tailored to meet the health needs of the patients of Bradford and West Yorkshire and developed working with partners to provide flexible models of care. The Quality Committee reviewed the Quality Plan in the context of the Clinical Strategy in order to develop the plan for 2019 onwards. The formal review of the implementation of the Quality Plan 2018/19 will be brought to the May 2019 meeting. Due to the new operational structure currently being implemented the strategy for 2019/20 will be resubmitted to the Quality Committee in September 2019. The Committee agreed the timescales were appropriate and the report was noted.	Director of Governance and Corporate Affairs Director of Governance and Corporate Affairs
Q.3.19.22	**Quality Report 2018-2019 Review** The draft report was discussed by TC noting much of the information will be unavailable until the year-end. The report will be further discussed at the Audit and Assurance Committee in April. No issues are identified and the timescales are on track. On completion of the final report, as previously, a short form of the document will be produced. The report in progress was noted by the Committee.	
Q.3.19.23	**Quality Improvement Programme Update Presentation** BG discussed the Quality Improvement presentation presented to the March Board development session. The quality improvement achievements were noted and the significant scale of work underway. BG discussed a session held at the Let's Talk event on 21 March 2019 where a list of over one hundred different elements of care were listed linked to the FT's fundamental standards. The Committee commended the work undertaken to date and the report was accepted by the Committee.	

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Q.3.19.24	**Proposed Terms of Reference of the Health, Safety and Resilience Committee** Following the Board and Board Committee self-assessment process identifying improvement opportunities in the governance infra-structure, TC noted the Health and Safety Committee and Resilience Committee had become the Health, Safety and Resilience Committee and was now a sub-Committee of the Quality Committee with the minutes now being received by the Quality Committee each quarter. TC noted high level reports from all sub-Committees of this Committee will be received by the Audit and Assurance Committee after April in order to note any exceptions, and the Terms of Reference of all sub-Committees will be provided to this Committee from a governance point-of-view. The report was noted by the Committee.	
Q.3.19.25	**Matters to escalate to the Strategic Risk Register** There were no issues to escalate to the Strategic Risk Register.	
Q.3.19.26	**Matters to Escalate to the Board of Directors** There were no matters to escalate to the Board of Directors.	
Q.3.19.27	**Board Assurance Framework (BAF)** The Committee reviewed the BAF taking into account the earlier discussions. The evidence received by the Committee has provided a significant degree of sustained confidence/improvement in relation to the achievement of the strategic objective to provide outstanding care for patients, with effective systems and processes in place alerting the Committee to any issues or risks in the strategic objectives. The clear and positive report was noted by the Committee and the assurance statement was revised.	
Q.3.19.28 **Q.3.19.28.1**	**Any Other Business** TC described a recent issue with waste disposal, resulting in additional requirements to store some types of clinical waste. The risk associated with this is being managed by the Integrated Governance and Risk Committee.	
Q.3.19.29	**Matters to share with other Committees** There were no matters to share with other Committees.	
Q.3.19.30	**Items for Corporate Communications** • IG Toolkit.	
Q.3.19.31	**Agenda items for meeting scheduled 24 April 2019** The draft agenda for the April meeting was noted. Additional agenda item: Risk strategy and quality management system.	
Q.3.19.32	**Date and time of next meeting** Wednesday 24 April 2019, 14:00-16:00, Conference Room, Field House, Bradford Royal Infirmary.	

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Q.3.19.33	**Confirmed minutes of the Health and Safety Committee (December 2018 meeting)** The confirmed minutes of the Health and Safety Committee were noted by the Quality Committee.	

Bradford Teaching Hospitals NHS Foundation Trust

BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST
ACTIONS FROM QUALITY COMMITTEE – 27 March 2019

Date of Meeting	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
30.01.19	Q.1.19.13	**Focus on: Safer Procedures** An updated of the work to be provided to the Quality Committee in April 2019.	Chief Medical Officer	24/04/19	Added to the agenda. Action concluded.
27/02/19	Q.2.19.6	**Board Assurance Framework (BAF)** The Committee agreed that the rationale for the assurance level, for the objective, to provide outstanding care for our patients, was agreed as, 'The Committee has increasing confidence that the structures and processes to identify and support the mitigation of risk associated with the achievement of this strategic objective are established'. The Quality Committee recognises the improvements that have been made. A formal review will take place of the previous twelve months at the April Quality Committee.	Director of Governance and Corporate Affairs	24/04/19	Added to the agenda. Action concluded.
27/02/19	Q.2.19.11	**Clinical Effectiveness Quarter 3 Report 2018/2019** The Committee recommended the High Priority Audit Plan is linked to the High Priority Improvement Plan which will be submitted to the Committee in April 2019 in order to streamline processes. The Committee agreed local audits will now only be undertaken if they link to quality, therefore, driving improvements.	Director of Governance and Corporate Affairs	24/04/19	Included on the agenda. Action concluded.

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27.03.19	Q.3.19.7	**Strategic Risks relevant to the Committee** TC will present the Trust's revised Risk Management Strategy and a paper describing the Trust's Quality Management System which together will demonstrate a clear route of escalation to this Committee at the April meeting of this Committee.	Director of Governance and Corporate Affairs	24/04/19	Included on the agenda. Action concluded.
27.03.19	Q.3.19.17	**Information Governance Toolkit** The Committee approved the submission of the Data Security and Protection Toolkit on behalf of the Board of Directors. An acknowledgement will be sent to the team.	Director of Governance and Corporate Affairs	24/04/19	
27.03.19	Q.3.19.21	**Clinical Services Strategy** The formal review of the implementation of the Quality Plan 2018/19 will be brought to the May 2019 meeting.	Director of Governance and Corporate Affairs	29/05/19	Added to draft agenda for May.
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	26/06/19	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

Date of Meeting	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
					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.
27/02/19	Q.2.19.19	**National Audit Care at End of Life** KD will further discuss with BG, discuss the findings at the Executive Management Group meeting and provide an update to the March meeting.	Chief Nurse	26/06/19	27.03.19: Report not yet published. Details to be submitted to the Quality Committee on publication.
30.01.19	Q.1.19.7	**Implications of new Committee Terms of Reference** 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	**Focus on: Infection Prevention and Control Exception Report** 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.	Chief Nurse	31/07/19	
30.01.19	Q.1.19.14	**Focus on: Infection Prevention and Control Exception Report** A progress report will follow in the Quarter 2 Infection, Prevention and Control report 2019.	Chief Nurse	31/07/19	

Date of Meeting	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
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	
27.03.19	Q.3.19.21	**Clinical Services Strategy** Due to the new operational structure currently being implemented the strategy for 2019/20 will be resubmitted to the Quality Committee in September 2019.	Director of Governance and Corporate Affairs	25/09/19	