

**QUALITY COMMITTEE
MINUTES, ACTIONS & DECISIONS**

Date:	Wednesday 24 April 2019	Time:	14:00 to 16:00
Venue:	Conference Room, Field House, Bradford Royal Infirmary	Chair:	Professor Laura Stroud Non-Executive Director
Present:	<p>Non-Executive Directors:</p> <ul style="list-style-type: none"> - Professor Laura Stroud, Non-Executive Director (LS) - Mr Jon Prashar, Non-Executive Director (JP) - Ms Selina Ullah, Non-Executive Director (SU) <p>Executive Directors:</p> <ul style="list-style-type: none"> - Ms Karen Dawber, Chief Nurse (KD) - Dr Bryan Gill, Chief Medical Officer (BG) - Ms Cindy Fedell, Chief Digital and Information Officer (CF) 		
In Attendance:	<ul style="list-style-type: none"> - Dr Tanya Claridge, Director of Governance and Corporate Affairs (TC) - Juliet Kitching (Minute taker) 		

No.	Agenda Item	Action
Q.4.19.1	Apologies for Absence There were no apologies for absence.	
Q.4.19.2	Declaration of Interests There were no declarations of interest.	
Q.4.19.3	Minutes and Actions of the Quality Committee meeting held on 27 March 2019 The minutes of the last meeting were approved as a correct record.	
Q.4.19.4	<p>Matters Arising</p> <p>The Committee noted that the following actions had been concluded:</p> <p>Q.1.19.13 (30.01.19) – Focus on: Safer Procedures.</p> <p>Q.2.19.6 (27.02.19) – Board Assurance Framework.</p> <p>Q.2.19.11 (27.02.19) – Clinical Effectiveness Quarter 3 Report 2018/2019.</p> <p>Q.3.19.7 (27.03.19) – Strategic Risks relevant to the Committee.</p> <p>Q.3.19.17 (27.03.19) – Information Governance Toolkit.</p>	Director of Governance and Corporate Affairs
Q.4.19.4.1	<p>Matters Arising from the Board of Directors</p> <ul style="list-style-type: none"> • Bo.3.19.8 (07.03.19): Board Assurance Framework (BAF) and Risk Appetite Statement – The assurances within the BAF were considered against the controls in place for the strategic risks associated with this Committee. The Committee discussed the Strategic Objective, 'To be a continually learning organisation', noting the integration with other strategic objectives, particularly the objective relating to the provision of outstanding care to patients. BG described that work around quality, research, education and by definition learning, is embedded in the quality strategic objective. The Committee agreed the objective could be more appropriately linked to the Trust's values or mission statement. A recommendation to review the 	

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	<p>strategic objective will be made to the Board of Directors on 9 May 2019.</p> <ul style="list-style-type: none"> Bo.3.19.10 (07.03.19): Following the Chair of the Quality Committee's report to the Board of Directors the Committee were requested to review the Operational Plan for 2019/20 in the context of the Terms of Reference. This item will be discussed in agenda item Q.4.19.17. 	
Q.4.19.4.2	<p>Matters Escalated from Sub-Committees</p> <p>LS reminded the Committee of the Sub-Committees of the Quality Committee:</p> <ul style="list-style-type: none"> 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. <p>There were no issues of note from the above.</p>	
Q.4.19.5	<p>Board Assurance Framework (BAF)</p> <p>LS noted the strategic objectives within the BAF for which the Committee has responsibility to assure and advise the Board of Directors.</p> <p>The Committee will consider whether there are any changes to the levels of assurance indicated during the meeting's discussions along with the strategic objectives for the next quarter. The level of assurance was amended at March's Quality meeting for the end of Quarter 4. Following Audit Yorkshire's review of the BAF, TC noted the format will be slightly amended. There will be no change to the content.</p>	
Q.4.19.6	<p>Quality Dashboard</p> <p>LS noted the quality dashboard to be part of the toolkit used for all exception reports received at this Committee, with the Quality Committee indicators aligned to the Trust's Strategic Objectives.</p> <ul style="list-style-type: none"> Night-time discharges between midnight and 6 am – The number of in-patient discharges were noted. These may be appropriate discharges, however, the type, source and reason for discharge are being identified. All discharged in-patients receive an assessment which considers the appropriateness and the availability of patients' external help and support. Complaints – Following recent improvement work in this area, KD noted this information should show a positive change from April 2019. MRSA bacteraemia performance – KD credited the targeted work of the team with only one case being reported within the last year. The Committee acknowledged this achievement. <p>The report was noted by the Committee.</p>	

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Q.4.19.7	<p>Quality Oversight System Report TC tabled the April 2019 report and the Committee noted the content.</p> <ul style="list-style-type: none"> Correspondence incidents – Effective processes and infrastructures are in place for managing risks and issues in order assurance can be provided to the Committee with the background information and other governance summaries as requested. Eleven incidents have been referred to the Quality of Care Panel meeting and 25 incidents to the Incident Performance Management Group. Themes and trends are explored, tracked and worked through with the clinical and surveillance groups. Maternity – The positive feedback of no outstanding concerns, subject to any further regulatory activity, at the engagement visit from the Care Quality Commission (CQC) on 12 April 2019 was noted. There was one issue regarding junior doctor staffing, however, midwifery nursing numbers have now been increased and this was noted to be positive. BG suggested Maternity is removed from the list of Live Quality Summits and the Committee agreed. <p>From the system-wide review of health around safeguarding children, the draft report has been received and is currently being checked for factual accuracy.</p> <ul style="list-style-type: none"> Haemoglobinopathy/Haematology – BG discussed the service and the formal Quality Summit process looking at the different aspects of the quality of care including the workforce. A letter had been received from NHS England/Improvement following which a Rapid Response Peer Review for the specialist service had been held. Positive verbal feedback was received, however, significant issues were raised in both the Haemoglobinopathy service and the Haemophilia service due to the requirements of a Specialist Service Centre, notably staffing and emergency and out-of-hours care pathways. A formal response is required in two weeks. The difficulty in recruiting consultants, throughout the region, with specialist expertise was also discussed. KD and BG have met with the team and a formal update of the response will be presented to the May Quality Committee. <p>The report was noted by the Committee.</p>	Chief Nurse/ Chief Medical Officer
Q.4.19.8	<p>Board Assurance Framework – 12 month formal review TC discussed the document tabled at the meeting reviewing the different elements of the BAF. An internal audit report had been undertaken which had a positive outcome with a number of recommendations described including linking the objectives to an agenda item. It was noted by the Committee that the content and focus of the BAF will remain unchanged, however, links will be formed between control, risks and accountability in relation to the strategic objectives. A control directory has been compiled indicating the control, the routine source of assurance, the code and the level of assurance. The list of high level controls to be rolled over into the next financial year were discussed and the list updated.</p>	
Q.4.19.9	<p>Focus on: Safer Procedures BG discussed the document entitled, 'Local Safety Standards for Invasive</p>	

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	<p>Procedures’.</p> <p>Following the publication in September 2015 by NHS England of a safety alert ‘Supporting the introduction of the National Safety Standards for Invasive Procedures’, the Foundation Trust (FT) developed local safety standards for invasive procedures to focus on reducing Never Events within all settings where invasive procedures occur.</p> <p>The report described the work carried out over the last three months looking at interventional procedures carried out, predominantly outside of the theatre environment. The Committee noted that the monitoring of safer procedures safety in our theatres had demonstrated positive assurance around a safety culture.</p> <p>The FT, assisted by Internal Audit, contacted all relevant departments and identified 146 invasive procedures. A quality improvement collaborative was introduced for each of the departments outside of theatres undertaking invasive procedures. The report depicted positive assurance around the level of engagement of staff and the number of checklists in place. A list of procedures have been noted where gaps were identified though some of these noted may not be invasive procedures. The checklists will be audited and adapted where necessary to ensure they formally match the Bradford Safety Standards for Invasive Procedures (BRADSSIPs).</p> <p>BG expressed his thanks to Dr L A Elliott (LAE), Deputy Chief Medical Director, Ms S Kasaven, Assistant Director of Clinical Governance, and the Safer Procedures Group, who have driven the programme and the positive engagement from the teams. KD referenced a recent very impressive presentation on this subject at the Band 7 Development Day by the Ward 2 Sister.</p> <p>Collaborative events have been held and the positive checking processes introduced around invasive procedures. All invasive procedures in the next few months will have checklists.</p> <p>The Committee commended and received assurance of the work of the team and LAE as Lead. An update report will be provided in 6 months’ time.</p>	<p>Chief Medical Officer</p>
<p>Q.4.19.10</p>	<p>Serious Incident (SI) Report</p> <p>The Committee considered the paper which summarised the serious incident profile of the Trust for March 2019.</p> <p>Four SIs were declared in March 2019:</p> <ul style="list-style-type: none"> • Two incidents resulting in patients suffering deep tissue injuries. • A patient who suffered harm as a result of not receiving appropriate follow-up appointments. • A patient who had suffered a stroke who experienced two separate falls, both falls resulting in fractures. This was identified as a delayed declaration of a serious incident, however, there had been no breach in Duty of Candour as this had been enacted as the incidents were recognised as notifiable. <p>No Never Events were declared in March 2019.</p>	

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	<p>One SI investigation was concluded in March 2019:</p> <ul style="list-style-type: none"> • SI 2018/28863 – Sub-optimal management of a long standing wound resulted from the District Nursing service using different wound management protocols. The Committee noted that learning will be shared and discussed through all specialty governance in relation to: <ul style="list-style-type: none"> - when it is appropriate to request a second opinion on treatment, - when delays in healing are evident. <p>The Committee noted that the RCA report will be shared by Commissioners with the Care Trust once signed off by the Commissioners.</p> <p>The Committee noted the report and was assured that the Trust has processes in place to identify, investigate and learn from serious incidents.</p>	
Q.4.19.11	<p>Quarterly Patient Safety and Health and Safety Management and Compliance Incident Report</p> <p>TC presented the quarterly report received by the Committee which informed the Committee of incidents, themes, trends, actions and learning related to the safety of patients, health and safety management and compliance from 1 January 2019 to 31 March 2019 including:</p> <ul style="list-style-type: none"> • Trust-wide incident profile – The incident reporting rate for Quarters 1 and 2 showed a decrease compared to Quarters 3 and 4. NHS Improvement published data for Quarters 1 and 2 which suggested a decrease in reporting per bed days compared to the previous year, however, the work completed by the FT on making bed days accurate was assessed as being the causal factor for this potential area of concern. • Patient safety incidents, claims and inquests. • Health and Safety incidents and risks to compliance. • The effectiveness of actions taken following a Serious Incident. • Summary of the publication of Never Events in England, 1 April 2018 to 28 February 2019. The national profile of Never Events was discussed. The FT is reported to have four cases as the Never Event stood down has not been removed. The shared learning hubs were noted. <p>TC noted the Health Care Safety Investigation Branch reports are tracked for learning through the FT's learning systems.</p> <p>BG noted the national concern in relation to the issue of the connection of patients requiring oxygen to air flow meters, and not the oxygen flow meters noting the serious harm caused by errors in other hospitals (the adaptors can fit into both wall mounted sockets which are side by side). Companies who manufacture the adaptors are multi-national and this error has been reported 44 times in just under twelve months. The work being undertaken by the Trust in relation to this was described.</p> <p>The report was received and the findings noted.</p>	
Q.4.19.12	<p>Nurse Staffing Data Publication – March 2019</p> <p>KD highlighted the key points in the March report which noted:</p> <ul style="list-style-type: none"> • Numbers remain static and stable. 	

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	<ul style="list-style-type: none"> Ward 6 identified a poor ward accreditation in February 2019. BG and KD have agreed to reduce the number of beds on ward 6 for a period of time whilst the ward gets 'back to basics'. The ward illustrates no evidence of harm. The FT is working closely with Airedale with the issue of nurse staff vacancies. The work the stroke team had undertaken for the Sentinel Stroke National Audit Programme was excellent and the recognition received was well deserved. Improvement should be identified with the new management structure enabling a change in behaviours and culture. A risk assessment has been undertaken, mitigation is in place and a revised plan will be in operation by the end of May 2019. The Committee agreed a Non-Executive Director walkround would be organised in one month's time. In March 2019 Ward 23 received a poor ward accreditation with regard mainly to the presentation of the ward. The Matron had been absent but has now returned and improvements are expected. <p>The report was accepted by the Committee.</p>	<p>Director of Governance and Corporate Affairs</p>
<p>Q.4.19.13 Q.4.19.14</p>	<p>Information Governance (IG) Report Senior Information Officer Report (SIRO)</p> <p>CF reported the Data Security and Protection Toolkit was submitted on 28 March 2019, on time. There was 97% compliance for training against a target of 95%. This is the highest level of IG training achieved. There have been no high risk IG or Cyber Security incidents in March 2019.</p> <p>At its last meeting the IG Sub-Committee reviewed in detail a number of Datix incidents instead of the summary. This review noted a high level of awareness of IG in the Trust. With the General Data Protection Regulation, the Trust is expected to have a Data Protection Officer that reports directly to the Board on data protection. The Joint Head of IG is the Trust's Data Protection Officer. She is planning to provide the annual report to the Quality Committee and then to the Board of Directors in July 2019. The importance of training, engagement and maintaining an open reporting culture was noted.</p> <p>CF noted the data quality section of the report that illustrates the position of the quality of business critical data is being revised to better demonstrate the position. She also noted that the team is drafting a Data Quality Framework which is a first for the Trust and will be brought to the Committee. The Framework will outline the controls and governance in place for data quality.</p> <p>The reports were noted by the Committee with recognition to the team on the work that has been undertaken.</p>	
<p>Q.4.19.15</p>	<p>High Priority Clinical Audit Plan 2019-2020</p> <p>TC described the plan developed with a wide range of consultation from care groups, specialties and from a review of nationally mandated clinical audit requirements. Once agreed by the organisation this will be submitted to the Commissioners for agreement. The plan includes 83 national clinical audit programmes which includes 46 mandatory National Clinical Audit and Patient Outcome Programmes. In addition there are 15 Trust and 9 Divisional High Priority Audit Programmes.</p> <p>BG and TC had met to discuss the interface required for quality improvement and audit in order to produce the Quality Account. This focused on the delivery of the required national programme. Due to the current systems in place, TC</p>	

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	<p>discussed the difficulties in measuring performance associated with the local audits. The Quality Governance and Quality Improvement (QI) team will consider the capture of audits undertaken within the QI Programme for inclusion in the Quality Account for 2019/20.</p> <p>The Committee approved the report.</p>	
Q.4.19.16	<p>Leadership Walkround Quarterly Update</p> <p>TC discussed the revised approach to Executive walkrounds focusing on engagement and using the FT's values as their basis. It was noted the new approach has been well received by those participating in them. The report will be circulated to the Non-Executive Directors and the feedback from last year's walkrounds will be considered with the reports submitted to the Chair's forum.</p> <p>The report was accepted and noted by the Committee.</p>	Director of Governance and Corporate Affairs
Q.4.19.17	<p>2019/2020 Operational Plan</p> <p>In Matthew Horner's (Director of Finance) absence discussion of the plan was deferred until the next meeting.</p>	Director of Finance
Q.4.19.18	<p>2019/2025 Risk Management Strategy</p> <p>TC discussed the FT's Risk Management Strategy submitted to the Committee for information. The original Risk Management Strategy was ratified by the Board of Directors in November 2017. Audit Yorkshire have undertaken an internal audit which provided significant assurance. The report has been discussed at the Integrated Governance and Risk Committee and the Audit and Assurance Committee and will be presented to the Board of Directors. Following discussions at these Committees, the Risk Management Strategy will now be a six year strategy.</p> <p>The document was noted and the work commended by the Committee.</p>	Director of Governance and Corporate Affairs
Q.4.19.19	<p>Quality Management System</p> <p>The FT developed and implemented a quality management system during 2016/17 which also provided a key infrastructure for quality governance and associated assurance processes.</p> <p>The Committee was assured that the Quality Management System within the FT is appropriately designed providing appropriate assurance in relation to its effectiveness.</p> <p>TC will consider the possibility of an infographic design to describe the system and this report will be added as an appendix to the Chair of the Quality Committee's report at the next Board of Directors' meeting, in order this is appropriately communicated.</p> <p>The report in progress was noted by the Committee.</p>	Director of Governance and Corporate Affairs
Q.4.19.20	<p>Draft BTHFT Quality Report 2018/19</p> <p>TC noted the Committee had been provided with the very latest version of the report. Further information will be added as the review process continues, the</p>	Director of Governance and

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	Committee will be requested to approve the Quality Account in the context of the governance designed to support its development by the 20 May 2019.	Corporate Affairs
Q.4.19.21	<p>Any Other Business There was no other business to discuss.</p> <p>At this point LS discussed the BAF following the meeting's discussions and the following were noted:</p> <ul style="list-style-type: none"> The two risks, haemoglobinopathy and security management standards for providers had previously been considered. The escalation/de-escalation management of escalating challenging behaviours will be at a reduced level following assessment and with immediate mitigations related to the monitoring of vital signs during periods of restraint and for a period after restraint being put in place during April 2019. <p>The Committee were assured following the discussions.</p>	
Q.4.19.22	<p>Matters to share with other Committees There were no matters to share with other Committees.</p>	
Q.4.19.23	<p>Matters to escalate to the Strategic Risk Register There were no issues to escalate to the Strategic Risk Register.</p>	
Q.4.19.24	<p>Matters to Escalate to the Board of Directors Quality Management System – Report to be submitted with the Chair's report.</p>	
Q.4.19.25	<p>Items for Corporate Communications</p> <ul style="list-style-type: none"> Note of thanks to the IG team. 	
Q.4.19.26	<p>Agenda items for meeting scheduled 29 May 2019 The draft agenda for the May meeting was noted. To add: Operational Plan, Haemoglobinopathy/Haemophilia Exception report.</p> <p>A generic request was made for lead authors to attend the Quality Committee and present their reports. This was considered good practice and agreed. TC noted the Committee need to be mindful, however, of the time allocated for each item.</p>	
Q.4.19.27	<p>Date and time of next meeting Wednesday 29 May 2019, 14:00-16:00, Conference Room, Field House, Bradford Royal Infirmary.</p>	



Bradford Teaching Hospitals
NHS Foundation Trust

BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST
ACTIONS FROM QUALITY COMMITTEE – 24 April 2019

Date of Meeting	Agenda Item	Required Action	Lead	Timescale	Comments/Progress
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	On May agenda – <u>Action concluded</u>
24.04.19	Q.4.19.4.1	Matters Arising from the Board of Directors Bo.3.19.8 (07.03.19): BAF and Risk Appetite Statement – A recommendation to review the strategic objective will be made to the Board of Directors on 9 May 2019.	Director of Governance and Corporate Affairs	29/05/19	
24.04.19	Q.4.19.7	Quality Oversight System Report Haemoglobinopathy/Haematology – KD and BG have met with the team and a formal update of the response will be presented to the May Quality Committee.	Chief Medical Officer/ Chief Nurse	29/05/19	On May agenda – <u>Action concluded</u>
24.04.19	Q.4.19.12	Nurse Staffing Data Publication – March 2019 Ward 6 – The Committee agreed a Non-Executive Director walkround would be organised in one month's time.	Director of Governance and Corporate Affairs	29/05/19	
24.04.19	Q.4.19.16	Leadership Walkround Quarterly Update The report will be circulated to the Non-Executive Directors and the feedback from last year's walkrounds will be considered with the reports submitted to the Chair's forum.	Director of Governance and Corporate Affairs	29/05/19	
24.04.19	Q.4.19.17	2019/2020 Operational Plan Deferred until the May meeting.	Director of Finance	29/05/19	On May agenda – <u>Action concluded</u>

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24.04.19	Q.4.19.18	2019/2025 Risk Management Strategy The report will be presented to the Board of Directors.	Director of Governance and Corporate Affairs	29/05/19	Presented to Board in May – Bo.5.19.32 – <u>Action concluded</u>
24.04.19	Q.4.19.19	Quality Management System TC will consider the possibility of an infographic design to describe the system and this report will be added as an appendix to the Chair of the Quality Committee's report at the next Board of Directors' meeting, in order this is appropriately communicated.	Director of Governance and Corporate Affairs	29/05/19	Added to July open board agenda – <u>Action concluded</u>
24.04.19	Q.4.19.20	Draft BTHFT Quality Report 2018/19 Further information will be added as the review process continues, the Committee will be requested to approve the Quality Account in the context of the governance designed to support its development by the 20 May 2019.	Director of Governance and Corporate Affairs	29/05/19	Approval sought and received from Committee members with paper confirming as such received by the Audit and Assurance Committee on 21 May 2019. <u>Action concluded.</u>
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	On June agenda - 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. 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

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					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	On June agenda - 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	24/07/19	
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	24/07/19	
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	24/07/19	
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	



Bradford Teaching Hospitals
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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	
24.04.19	Q.4.19.9	Focus on: Safer Procedures The Committee commended and received assurance of the work of the team and Dr L A Elliott as Lead. An update will be provided in 6 months' time.	Chief Medical Officer	30/10/19	