

QUALITY AND PATIENT SAFETY ACADEMY (QPSA) - LEARNING AND IMPROVEMENT MINUTES

Date:	Wednesday 29 March 2023	Time:	14:00-16:30
Venue:	Microsoft Teams meeting	Chair:	Mohammed Hussain, Non-Executive Director/Chair
Present:	<p>Non-Executive Directors:</p> <ul style="list-style-type: none"> - Mr Mohammed Hussain (MH), Non-Executive Director - Mr Jon Prashar (JP), Non-Executive Director - Ms Sughra Nazir (SN), Non-Executive Director <p>Executive Directors:</p> <ul style="list-style-type: none"> - Dr Ray Smith (RS), Chief Medical Officer - Professor Karen Dawber (KD), Chief Nurse 		
Attendees	<ul style="list-style-type: none"> - Mr John Bolton (JB), Deputy Chief Medical Officer/Operations Medical Director - Dr Deborah Horner (DH), Deputy Chief Medical Officer - Ms Judith Connor (JC), Associate Director of Quality - Ms Louise Horsley (LH), Senior Quality Governance Lead - Mrs Sara Hollins (SH), Head of Nursing, Midwifery - Ms Laura Parsons (LP), Associate Director of Corporate Governance/Board Secretary - Ms Faye Alexander (FA), Head of Education - Ms Joanne Hilton (JH), Deputy Chief Nurse - Dr LeeAnne Elliott (LAE), Consultant Paediatric Radiologist - Ms Adele Harley-Spencer (AHS), Director of Nursing – Operations - Ms Leah Richardson (LR), Patient Safety Specialist - Dr Robert Halstead (RH), Associate Medical Director Quality Governance, Emergency Department - Ms Liz Tomlin (LT), Head Of Quality Improvement and Clinical Outcomes - Sally Scales (SS), Director of Nursing: Programme Lead for Magnet - Ms Joanna Stedman (JS), Deputy Director of Nursing, Specialist Medicine CSU - Ms Jane Kingsley (JK), Lead Allied Health Professional - Ms Padma Munjuluri (PM), Associate Medical Director-Clinical Outcomes - Ms Sarah Turner (ST), Assistant Chief Nurse Vulnerable Adults, for agenda item QA.3.23.12 only - Mr Michael McCooe (MM), Associate Medical Director, Learning from Deaths 		
In Attendance:	<ul style="list-style-type: none"> - Ms Kay Pagan (KP), Assistant Chief Nurse, Informatics - Ms Sarah Smith (SSm), Quality & Patient Safety Facilitator - Ms Katie Shepherd (KS), Corporate Governance Manager - Ms Jessica Barker-Roe, Minute-taker 		
Observer	<ul style="list-style-type: none"> - Ms Helen Wilson, Staff Governor - Mr Nazzar Butt, Moving to Outstanding Lead 		

Agenda Ref	Agenda Item	Actions
QA.3.22.1	Apologies for Absence	
	<ul style="list-style-type: none"> - Mr Altaf Sadique, Non-Executive Director - Dr Harry Ashurst, Associate Medical Director - Dr Paul Rice, Chief Digital and Information Officer, represented by Kay Pagan 	
QA.3.22.2	Declarations of Interest	
	There were no declarations of interest.	
QA.3.22.3	Draft minutes of the meeting held on 22 February 2023	
	<p>The minutes of the meeting held on 22 February 2023 were approved as a correct record.</p> <p>The Academy noted that the following actions had been concluded:</p> <p>QA23006 – QA.1.23.17 (25.01.2023) – High Level Risks</p> <p>QA23004 – QA.1.23.12 (25.01.2023) – Patient Safety Incident Response Framework (PSIRF)</p> <p>QA23005 – QA.1.23.13 (25.01.2023) – Quality Account – Quarterly Progress Report</p> <p>QA23009 – QA.2.23.5 (22.02.2023) – Quality and Patient Safety Academy Dashboard</p> <p>QA23011 – QA.2.23.7 (22.02.2023) – Serious Incident Report</p> <p>QA23012 – QA.2.23.9 (22.02.2023) – Patient Experience Interpretation Services – Risks relating to Language/Communication</p> <p>QA23013 – QA.2.23.9 (22.02.2023) – Patient Experience Interpretation Services – Risks relating to Language/Communication</p> <p>QA22020 / QA23016 - QA.4.22.13 / QA.2.23.14 (27.04.2022 / 22.02.2023 – Clinical Outcomes Group / Clinical Audit Policy including National Confidential Enquiries</p>	
QA.3.22.4	Matters arising	
	There were no matters arising from the Minutes that were not already on the agenda. Verbal updates were given at the meeting on the outstanding and closed actions and these were reflected in the action log.	
QA.3.23.5	Research Activity in the Trust – Update	
	RS gave an overview of the Research Activity in the Trust as detailed within the report, which had been circulated to colleagues to highlight the developments that are occurring within the research team. RS explained that a look in to the difference that research is making to our patients will help the Trust to further understand the population's needs. Details of the following projects were highlighted:	

	<ul style="list-style-type: none"> - New Trust Research Strategy – “A Research Strategy for Health and Wellbeing - Delivering research excellence together”. RS shared that the final draft is being launched this month, noting that this compliments the Trust Strategy, focusing on people, partnerships and the place. RS commented that this is a positive step which demonstrates that The Bradford Institute for Health Research (BIHR) is closely aligned to the trust. - Learn Together Project. This work explores the experiences of patients and their families. RS shared that this research had recently won the 2022 Health Business Awards Patient Safety Award. - Patient Wellness Assessment. The Worry and Concern programme pilot launched on Ward 21 to help identify early changes in deteriorating patients. - Community Health Checks In collaboration with local Primary Care Network, Bradford for Better and Improvement Academy. Due to socio-economic difficulties, a high proportion of the Bradford population do not have wellness checks. Therefore events held in the community have boosted attendance and found a number of health issues that would otherwise have been untreated. <p>MM commented on how valuable this work is, noting a clear need for this in the population. He commended the willingness of involvement both in the Trust and in the community, adding that due to the success the project will continue to grow and develop.</p> <p>RS added that the Research Dashboard is currently being produced and will be visible across the Trust, with opportunities for everyone to get involved in the research.</p> <p>The Academy noted the update.</p>	
QA.3.23.6	Serious Incidents Report (Focus on learning)	
	<p>LH provided an overview of the Serious Incident February 2023 report, which was taken as read by the Academy. The following key points were highlighted:</p> <ul style="list-style-type: none"> - The Statistical Process Control (SPC) chart has been reduced to cover one year, rather than five years, which can be found on page 4 of the report. - 3 Serious Incidents (SIs) were declared in the month of February. LH gave detail of the learning from the three SIs closed. - There have been no ‘never events’ or Duty of Candour (DoC) breaches in this period. LH noted that a definition of a DoC breach can be found on page six of the report, as requested by the Academy. - 19 SIs remain ongoing, with the position improving. - 4 SIs have been completed in the month of February. 	

	<p>There was a discussion regarding SI2023/3178, in which SN questioned whether retrospective completion of Deprivation of Liberty Safeguards (DoLS) assessments were occurring due to a wider training need. SN also queried the level of information shared with the Police with regards to vulnerable patients. LH shared details of the case to give further insight. In addition, KD explained the reasoning behind the use of retrospective DoLS and detailed the work that can be done with the police going forward. KD suggested that ST do some work with the local police on how the Trust can make improvements to their communication regarding vulnerable patients, bringing a report to the Academy in four months' time.</p> <p>SN made a further query regarding SI 2021/24499, recognising that it appears to have been open for some time. LH clarified that the report is in a final draft stage at the moment, as it was on hold until the conclusion of a police investigation closing in Summer 2022.</p> <p>MH thanked the Quality team for a comprehensive report. The Academy was assured by the update provided.</p>	<p>QA23017 Assistant Chief Nurse Vulnerable Adults</p>
QA.3.23.7	Patient Safety Incident Response Framework (PSIRF)	
	<p>LR introduced the slide pack, detailing an update of the learning from the Patient Safety Incident Response Framework (PSIRF). LR reported that there has been a focus on patient safety incident reports, patient experience, FFT, claims and litigation followed by a staff engagement event to bring together and define priority areas.</p> <p>LR outlined the work that is ongoing to implement the PSIRF, including a meeting with the Coroner's office, mapping out training requirements, and using data to calculate the required capacity for Patient Safety Incident Investigations (PSIIs). LR added that there will be a Board session on 20th April 2023 to look at how PSIRF is being implemented across the NHS</p> <p>MH queried the time frame of the 44,000 incidents cited in the presentation, which LR clarified was 3 years.</p> <p>The Academy noted the update.</p>	
QA.3.23.8	Quality Account – Quarterly Progress Report	
	<p>JC introduced the presentation circulated with the agenda, which outlined updates from the 2022/23 Quality Improvement Priorities, and the Priorities for the 2023/24 Quality Account.</p> <p>Updates and recommendations for each of the 2022/23 Quality Improvement Priorities were shared. The Priorities were listed as:</p> <ol style="list-style-type: none"> 1. Improving the management of deteriorating patients <ul style="list-style-type: none"> - Improve the usage of the deteriorating patient tile - Sepsis screening - Time to Treatment 	

	<ol style="list-style-type: none"> 2. Improving patient experience 3. Continued reduction in stillbirths 4. Advancing equality, diversity and inclusion. <p>With regards to Priority 1, there was a discussion regarding sepsis screening, in which data appeared inaccurate due to maternity being on Cerner. SN questioned whether the recommendation of receiving antibiotics within an hour of recognition of severe sepsis was difficult to achieve. RS confirmed that the target was achievable due to the clarity of the symptoms of severe sepsis (this was supported by a graph displayed in the presentation). It was identified that current issues were caused by the systems used to identify sepsis, meaning it is a reporting issue rather than management of patients. JC added that as national guidelines are changing, there is a requirement to build a new sepsis tool embedded within the Trusts EPR system.</p> <p>JC explained that in identifying Quality Priorities it is important to recognise their interconnectivity, and ensure they are driven by data so that the impact can be measured. JC detailed the ways in which the Trust will meet the National Patient Safety Priorities for patient Safety Specialist, and provided an insight in to how we embed our learning from patient safety incidents.</p> <p>To conclude, JC shared the proposed Quality Priorities for 2023/24:</p> <ol style="list-style-type: none"> 1. Improving the management of deteriorating patients. 2. New: Implementing Saving Babies Lives Care bundle (version 3). 3. New: Improving patient experience by advancing equality, diversity and inclusion. 4. New: Implementation of Patient Safety Response Framework. <p>KD praised JC for an informative presentation, commenting that bringing patient experience and equality, diversity and inclusion together strengthens them.</p> <p>The Academy noted the update.</p>	
QA.3.23.9	Learning from Deaths/Mortality Review Improvement Programme	
	<p>MM provided an overview of the presentation circulated with the agenda; this highlighted the details of excess mortality numbers which were recorded across in the country in December 2022. MM explained that the Trust carried out some further analysis following 189 adult inpatients deaths in this time period, finding that the most prevalent causes of death were respiratory infections and cardiac causes. The learning taken was shared, highlighting in particular important links with Virtual Royal Infirmary.</p> <p>RS observed how excellent the current insight in to mortality is in the Trust, commenting that it as a major step forward for the organisation.</p>	

	<p>MH queried whether there was an opportunity concerning creating a risk around people with communication and learning difficulties. There was a discussion on how well the analysis works for people with communication difficulties, with Liz Tomlin sharing some insight in to work that has been done in this area. It was agreed that this would be brought to the academy for information at a later date.</p> <p>The Academy was assured by the update provided.</p>	
QA.3.23.10	Update from Maternity and Neonatal Services	
	<p>SH shared the presentation circulated with the appendices, which focused on highlights February paper, and the learning from SIs and HSIB (Healthcare Safety Investigation Branch) cases that were completed in February.</p> <p>The February update paper was summarised, with the following information highlighted:</p> <ul style="list-style-type: none"> - 7 ongoing maternity SIs/Level 1 investigations: 4 HSIB and 3 at Trust level. <p>SH noted that there were no new HSIB cases in February.</p> <ul style="list-style-type: none"> - 5 neonatal deaths in February, assurance is given by the neonatal team in appendix one; however there are no emerging themes or trends. <p>SH asked QPSA to note that there were no appendices or reports required to demonstrate compliance with the Maternity Incentive Scheme, requiring QPSA approval this month.</p> <p>SH provided details of 3 investigations that were completed in February. The learning, HSIB recommendations and progress of each case was detailed on the slides.</p> <p>MH commended SH on the level of data provided in the papers circulated to the Academy.</p> <p>There was a discussion regarding the outcome of births that occur outside of the hospital. SH explained that often this is due to birth progressing rapidly and precipitating unexpectedly; however the academy were assured that often there is no adverse outcome. SH shared that there is a piece of work ongoing to identify any themes and trends in this area, which will recognise if there is any need for further education to be put in place for the Maternity Assessment team. It was suggested that this can be shared with the Academy at a later date.</p> <p>Regarding one particularly distressing case, DH commented on how well the team in Maternity dealt with the challenges, recognising that a lot of learning had been identified.</p> <p>The Academy was assured by the update provided.</p>	
QA.3.23.11	Nursing and Midwifery Leadership Council Update (Magnet4Europe)	

	<p>SS gave an update on the Nursing and Midwifery Leadership Council (Magnet4Europe), sharing slides circulated to the Academy. It was explained that the aim of Magnet4Europe is to test the feasibility and sustainability of the Magnet model in European Healthcare Organisations. The focus being redesigning hospital workplaces to improve the mental health and wellbeing of nurses and physicians, to improve patient safety.</p> <p>SS shared some of the programme milestones since the November 2022 update, including a year 1 celebration event planned for May 2023 for the launch of the Nursing and Midwifery Strategy. SS acknowledged how exceptionally difficult recent years have been, but emphasised the importance of recognising how much there is for the Trust to be proud of in this period.</p> <p>SS explained that the learning since the November 2022 update includes various learning events and ongoing education programmes, including a visit from the US twin partner in May 2023. It was summarised that there are many opportunities for learning, encouragement and engagement both internally and externally.</p> <p>The Academy was assured by the update provided.</p>	
QA.3.23.12	Mental Health Strategy	
	<p>ST shared slides giving an overview of the Mental Health Strategy, calling attention to Appendix 1, distributed in order to give some wider context.</p> <p>ST provided detail of the progress made in relation to mental health in recent years. This included developments in training, workforce, information sharing and partnerships. It was shared that going forward the next steps will be to engage experts, develop training further to include necessary specific areas, and build on the future workforce by consulting with university students regarding opportunities with the Trust.</p> <p>ST highlighted that a key piece of work currently is around making sure the Trust has a better oversight of attendances under Section 136 (Police detention monitoring in A&E). ST explained the importance of being mindful that the Emergency Department may not necessarily be a safe place for people with mental health problems, therefore this work looks at how disruption is minimised for both attendees and the department as a whole.</p> <p>MH thanked ST for a very helpful update. The Academy was assured by the update provided.</p>	
QA.3.23.13	High Level Risks	
	RS explained that there are 13 high level risks which are aligned to	

	<p>the Academy. It was summarised that all risks are within their review date; no new risks have been added since the March Quality and Patient Safety Academy meeting, and no risks have been closed.</p> <p>In terms of change, RS highlighted risk 3469, noting that the risk score has changed from 15 to 16. Though it was noted that there has been no significant change, only that the score had been miscalculated in the first instance.</p> <p>RS went on to advise the Quality and Patient Safety Academy that there will be Junior Doctor Industrial Action in April 2023, taking place over 96 hours continuously. Sharing, that the concern around this particular Industrial Action is of a higher order of magnitude than the previous strike. It was explained that this is due to a number of factors including being over a longer period and occurring after a four day bank holiday weekend, factoring in possible staff holidays, and anticipated less enthusiasm. In light of a significant risk, RS advised that a great deal of planning is being done to mitigate the impact.</p> <p>MH questioned whether there was an updated risk concerning these particular strikes, however RS explained that the existing risk is generic in relation to all strikes. There was some question whether it would be appropriate to amend the risk given the likelihood of changing risk scores as things progress. It was decided that there would be an update to the risk narrative, and the risk score as appropriate.</p> <p>The Academy was assured by the update provided.</p>	QA23018 Chief Medical Officer
QA.3.23.14	Clinical Audit Policy including National Confidential Enquiries	
	<p>LT gave an overview of the purpose of the paper, distributed to the Academy for approval. It was explained that the paper is a revision of the Clinical Audit Policy, with updates made to reflect changes following organisational re-modelling in September 2022. LT advised that the aim of the changes is to ensure that the organisation is meeting the recommendations for the National Clinical Audit Programme, and can demonstrate how this is done through sharing learning.</p> <p>LT welcomed any thoughts or comments on the policy which was distributed in advance to the Quality and Patient Safety Academy.</p> <p>The academy approved the Clinical Audit Policy.</p>	
QA.3.23.15	Any Other Business	
	<p>MH noted his absence for the May Quality and Patient Safety Academy, recognising the need for a deputy Chair.</p> <p>Clarification was provided around point 9 in the Clinical Outcomes Group minutes.</p>	

	SN queried whether there had been any progress in the Duty of Candour update highlighted in the Patient Safety Group minutes (QA.3.23.21). KD and JC gave a detailed explanation on why there had been some change in reporting under Duty of Candour. SN thanked KD and for the clarification.	
QA.3.23.16	Matters to share with other Academies	
	There were no matters to share with other Academies.	
QA.3.23.17	Matters to escalate to the Board of Directors	
	There were no matters to escalate to the Board of Directors.	
QA.3.23.18	Date and time of next meeting	
	26 April 2023, 14:00-16:00 – Assurance meeting	
	Annexes for the Quality and Patient Safety Academy Annex 1 – Documents for Information	
QA.3.23.19	Clinical Outcomes Group	
	Noted for information.	
QA.3.23.20	Patient Experience Group	
	Noted for information.	
QA.3.23.21	Patient Safety Group – February 2023 and March 2023	
	Noted for information.	
QA.3.23.22	West Yorkshire Association of Acute Trust Quality and Safety Meeting Update	
	Noted for information.	
QA.3.23.23	Quality and Patient Safety Academy Work Plan	
	Noted for information.	
QA.3.23.24	Internal Audit Reports relevant to the Academy Safer Procedures; National Safety Standards for Invasive Procedures (NatSSIPs) BH/26/2023	
	Noted for information.	



ACTIONS FROM QUALITY AND PATIENT SAFETY ACADEMY – March 2023

Assurance Meeting Actions

Learning and Improvement Actions

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
QA22056	30.11.22	QA.11.22.6	Quality Account – Progress Report PSo agreed to provide data to benchmark the Trust against other Cerner Trusts regarding sepsis screening and Time to Treat.	Chief Digital and Information Officer	April 2023	09.12.22: Action update requested. 14.12.22: Action rolled over to the January meeting. 13.01.22: Contacted for update. 25.01.23: PR agreed to provide an update at the February meeting. 22.02.23: PR – No definitive answer. The Trust is working with other Cerner Trusts. There was no Cerner Special Interest Group in January 2023. PR has reached out to colleagues in other Trusts to understand whether they have a perspective on how this is undertaken. PR to update upon receipt of any response and the issue will be discussed at the Cerner Special Interest Group meeting. 29.03.23: KP advised that the feedback from two other organisations that use Cerner is pending.
QA23001	25.01.23	QA.1.23.5	Serious Incident (SI) Report (focus on learning) PR noted the whole Recommended Summary	Chief Digital and Information	April 2023	29.03.23: KP advised that a paper has gone to ETM to ask for it to be built in to EPR, now needs to be

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			Plan for Emergency Care and Treatment (ReSPECT) agenda, in relation to the EPR remains a high priority agenda item for both Bradford Teaching Hospitals and Airedale with full commitment from consultant colleagues. PR agreed to provide an update on the ReSPECT EPR agenda at the March QPSA.	Officer		shared across SystemOne and Cerner. KP/PR to bring priority list to QPSA. 17.04.23: To be covered at the April 2023 meeting under agenda item QA.4.23.11
QA23007	22.02.23	QA.2.23.4	Matters Arising Quality Strategy (Linked to Action ID – QA22035 (29.06.22) QA.6.22.14) The Quality Strategy will be brought to the QPSA in due course with final comments.	Associate Director of Quality	April 2023	29.03.23: JC advised that work was ongoing on the Quality Strategy. To update at the next meeting.
QA23014	22.02.23	QA.2.23.9	Patient Experience Interpretation Services – Risks relating to Language/Communication KD proposed a risk is set up on the Corporate Risk Register and monitored under the auspices of the QPSA to link in with the Equality, Diversity and Inclusion (EDI) Council and strategy work.	Associate Director of Corporate Affairs/Board Secretary	April 2023	21.03.23: Risks already included on the BAF in relation to both EDI and understanding the needs of our population. To be considered as part of the annual BAF review in March/April 2023. 29.03.23: LP advised the BAF is currently being reviewed, and will go to the Board Development Session and Academies in April. 17.04.23: The BAF is included on the agenda for review (item QA.4.23.9). CLOSED
QA22065	14.12.22	QA.12.22.6	Quality and Patient Safety Academy Dashboard Sepsis – Sepsis screening is running around 55 to 60% as a result of the Electronic Patient Record (EPR) flow tool. Processes were described with a confidence that patients are	Chief Digital and Information Officer	April 2023 (Assurance meeting)	17.04.23: To be covered at the April 2023 meeting under agenda item QA.4.23.11

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			receiving the appropriate treatment. The Academy agreed to retire the metric for three months in order to allow PSo and colleagues to look into this further, providing analysis on this key metric and in order a full review of sepsis screening can be measured (linked to Action QA22056).			
QA23002	25.01.23	QA.1.23.6.2	Assurance from Neonatal Unit Serious Incidents Improvement of the Full Blood Count sample situation for the laboratory was queried. This work forms part of the overarching plan with other options being considered. An update on this issue will be provided to the April QPSA.	Senior Quality Governance Lead	April 2023	
QA23003	25.01.23	QA.1.23.8	Palliative Care Annual Report KD noted a recent discussion around an electronic version of ReSPECT across place believing this to be an EPR priority awaiting special approval. A list of priorities was noted to be being presented to the Executive team meeting in the next two months. An update will, therefore, be provided to the April QPSA.	Chief Digital and Information Officer	April 2023	17.04.23: To be covered at the April 2023 meeting under agenda item QA.4.23.11
QA23015	22.03.23	QA.2.23.12	Maternity and Neonatal Services Update – January 2023 Seven on-going Serious Incident (SI)/Level 1 investigations relating to maternity events – Three are HSIB cases and four internal reviews. These cases will be presented at the next QPS Academy (Learning and Improvement).	Director of Midwifery	April 2023	17.04.23: SH advised that learning will be fed back on a monthly basis regarding completed SI/HSIB cases. Action to be closed as updates are ongoing. CLOSED

Action ID	Date of meeting	Agenda item	Required Action	Lead	Timescale	Comments/Progress
QA23018	26.03.23	QA.3.23.13	High Level Risks MH questioned whether there was an updated risk concerning Junior Doctor Strikes. RS explained that the existing risk is generic in relation to all strikes, therefore it was decided that there would be an update to the risk narrative, and the risk score as appropriate.	Chief Medical Officer	April 2023	19.04.23: Risk updated and amended to take in to account industrial action regarding Junior Doctors. CLOSED
QA22059	30.11.22	QA.11.22.9.1	Patient Experience – Six Monthly Report KB noted the difficulties sometimes experienced in retrieving information from the Trust's Datix system, due to limitations as how best to represent data. There have been previous discussions about how data could be improved as a large amount of data was reflected as "other". KB took as an action to revisit this again, to discuss and consider any options that would provide more meaningful data to this cluster. This system may be upgraded in time. Trust systems should, however, function fully.	Assistant Chief Nurse (KB)	May 2023	07.12.22: KB has contacted the Complaints Lead and Datix team and is awaiting feedback. 13.01.23: KD has requested this update is included in the next six monthly report from KB (due May 2023).
QA23008	22.02.23	QA.2.23.4	Matters Arising Discussion of Bristol Insight Model (Linked to Action ID – QA22067 (14.12.22) QA.12.22.14) – Work to be linked in with the other Trust priorities around Electronic Patient Record development.	Chief Digital and Information Officer	May 2023	
QA23010	22.02.23	QA.2.23.5	Quality and Patient Safety Academy Dashboard Sepsis - The Academy discussed the continuing issues with the sepsis tile. PR agreed to provide an update going forward following the next scheduled meeting of the	Chief Digital and Information Officer	June 2023	

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			Cerner Special Interest Group where all Cerner using Trusts share intelligence and insight regarding their respective approaches to deriving benefits from using the system to best effect.			
QA23017	26.03.23	QA.3.23.6	Serious Incidents Report (Focus on learning) ST to do some work with the local police on how the Trust can make improvements to their communication regarding vulnerable patients, bringing a report to the Academy in four months' time.	Assistant Chief Nurse Vulnerable Adults	July 2023	
QA23019						