The Royal Wolverhampton NHS Trust

Approved Minutes of the QGAC Committee of 20 March 2019

13 May 2019

Agenda Item No: 12.8

Minutes of the Quality Governance Assurance Committee

held on the:

Date **Wednesday 20 March 2019**

Venue **Room 1, WMI**

Time **2.00pm to 4.00pm**

	Name	**Role**
Present:	R Edwards **(RE)** - Chair	Non-Executive Director
	A M Cannaby **(AMC)**	Chief Nursing Officer
	S Field **(SF)**	Trust Chair from 1 April 2019
	S Hickman **(SH)**	Compliance Manager
	D Loughton **(DL)**	Chief Executive
	M Martin **(MM)**	Non-Executive Director
	G Nuttall **(GN)**	Chief Operating Officer
	Dr J Odum **(JO)**	Medical Director
	J Vanes **(JV)**	Trust Chair
Attendees:	S Cotterill **(SC)**	VTE – Clinical Nurse Specialist
	T Palmer **(TP)**	Head of Nursing & Midwifery Women's & Neonatal Services
Apologies:	M Arthur	Head of Governance
	V Whatley	Deputy Chief Nursing Officer

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1	**Apologies for absence** Apologies were noted.	
1a	**Declarations of Interest** There were no Declarations of Interest.	
2	**Minutes of Previous Meeting - Quality Governance Assurance Committee:** Correction to page 3, line 2, should read 2018 **RESOLVED: Minutes of the Quality Governance Assurance Committee held on 20 February 2019 were approved as a correct record.**	
3	**Matters arising from the Minutes** The action log was updated accordingly. **VTE External Audit & Actions – S Cotterill** SC presented the above report and advised that work has been completed on last year's actions. Prior to last year's audit work had commenced on a new data base which would pull information in from different servers and this was shared with the external auditors at the time and asked if any issues could be identified and if it met the requirements that they were looking for. When the new database was implemented the team switched the criteria for how we report. Prior to last year the Trust reported VTE risk assessments based on during admission assessment and the auditor recommended that this was reviewed and look at one within 24 hours of admission, therefore over the last financial year this is what the Trust has reported. It was envisaged that there would be a drop in the compliance once the Trust had changed the reporting process and there were a few other obstacles to overcome during the year which also impacted on the compliance. There were changes within the portal and also a big change in Maternity (installation of BadgerNet). Work has been undertaken with all of the departments to reduce the amount of patients that are left more than 24 hours without a VTE assessment. SC confirmed that support had been received from the Executive Team with communications and monitoring of areas. Progress has been made, however it is not where SC would like it to be and there is still work to do and is hoping to be 95% compliant by March, February saw the figure at 93.79%. In March the Trust is seeing a VitalPac upgrade which is not going to help with Trust compliance due to having most of the day where it will be impossible to generate VTE risk assessments but a business continuity plan is in place to revert to paper assessment and capture data. MM raised concerns in regards to the auditors last year qualified the Quality Accounts because the quality of the data did not underpin the percentage of what the Trust obtains and mentioned that the auditors stated that the data was unreliable. SC replied that this was in	

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	relation to the old database and the auditors have seen the new database prior to it going live and their opinion was sought and met their concerns already expressed. This was discussed further. AMC advised the meeting that NICE guidance states that the Trust should be monitoring patients between 16 and 80 year olds. However, the Trust is already doing this but the mandate to do this is from April 2019. AMC suggested that the Trust speaks to CCG and advise them of what the Trust is already doing. AMC praised SC and the Doctors working with her and offered thanks from everyone. **Audit Results – Emergency C-Section – T Palmer** TP presented the above report to the meeting and it was noted that the report was presented to the CQRM following concerns raised in relation to rising Caesarean section rates at the Trust. Mr Afifi, Consultant Obstetrician conducted an audit of Caesarean section cases performed between May 2018 to November 2018, in total there were 687 cases reviewed. The audit revealed that the Trust is not an outlier for total Caesarean section rates and as at the same time the NHS digital data was produced and that was showing the national rates for England were 29%. The emergency section rates for this Trust were 17.7% compared to the national average of 16%. The elective Caesarean section rate for the Trust is 11.1% compared to the national average of 13%. Therefore our total rate is just below 29%. TP discussed briefly the reasons for the elective Caesarean births and the emergency Caesarean section births. TP mentioned that national guidance aimed at improving outcomes, Saving Babies Lives Care Bundle (NHSE) and NICE guidance has impacted on rising induction of labour rates nationally. Recommendations from the audit include: • Following a meeting with the Directorate and reviewed the dashboard and indicators and readjusted them to enable the Directorate not to be always in the red. • Looked at developing a Local Maternity System (LMS) dashboard which is in progress but will change as the Saving Babies Lives second addition has been circulated. MM commented that the audit focussed on the immediate causes of requiring an emergency Caesarean section regarding the circumstances of the birth process itself. She asked if age, co-morbidities, social / economic background were taken into consideration. TP replied that not for this audit but a deeper dive audit is being considered when this would be covered. The meeting discussed the report and the Committee was assured.	
4	**Regular Reports**	
4.1	**Integrated Quality & Performance Report – February – A M Cannaby / G Nuttall** AMC presented the Quality section of the report. The meeting discussed the Mortality data and noted the amount of activity being conducted by the Medical Examiner. Prior to September 2018 there were 8 SJR1's outstanding, since	

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	September there are 86 SJR1's being chased, in total there are 94 SJR1's to be completed, these are being chased. When the SJR1 phase and Overall Care Outcomes graph was discussed MM asked if the colour code could be changed to better represent the status of care - Excellent, Good, Adequate, Poor - and the key to be provided. SH agreed to do this. AMC thanked everyone for the hard work in developing this section of the report. Complaints are still high in February and AMC has asked for details in readiness for the Trust Board meeting. There were six complaints in Emergency Department, two in C17, two in West Park and two on the Elderly Ward. MM queried the target on stroke and "patients admitted with primary diagnosis of stroke should spend greater than 90% of their hospital stay on a dedicated stroke unit" and asked if the target was 90% or greater than 80%. GN replied that 80% of patients should spend 90% of their time on the stroke ward. JO confirmed that this was the definition. RE mentioned that, having recently viewed the Sentinel Stroke National Audit Programme 2018 results from another Trust, she had looked at the 2018 results from this Trust, which were mostly around the national average. RE suggested that RWT's results should be circulated to this committee and that a representative attend to respond to queries. The meeting discussed this issue and agreed the importance of the Trust striving to improve performance. GN mentioned that there will be a two day WMQRS review of the stroke ward the following week. It was agreed that clinical and operational management would be invited to QGAC in June or July to take the committee through the findings and their proposed actions. GN presented the Performance section of the report and asked that it be taken by exception following in-depth discussions at the Finance & Performance meeting earlier. GN advised the meeting that the referral to treatment indicator in February deteriorated slightly and it is still a challenge. A presentation to Finance & Performance will take place in April in regards to referral to treatment and the specialties that are challenged. There is good progress on diagnostics with the team. Emergency Department are not green but in terms of benchmarking our performances are very good. February last year the Trust was at 76% compared to 81% on type 1's this February. The Trust is coping very well this winter. GN assured the committee that cancer was discussed in depth at the earlier meeting where the latest cancer action plan, which is updated monthly, was shared. GN mentioned that the Trust does not have the capacity for 2 week wait breast symptomatic referrals. MM commented that the amount of referrals was unbelievable. GN advised that normally the Trust receives on average 380 but recently the Trust is receiving 500 breast referrals. The proportion of women requiring treatment has remained the same, showing that the referrals are appropriate, and as a result we are treating more women. DL commented that this shows that the level we are now at is the level we should always have been at, and indicates that the demand will not diminish. The meeting was informed that this issue is a national problem. GN informed the meeting that the staff are working every Saturday for the past few months to try and help reduce the backlog. GN commented that there was a cancer meeting on Friday chaired by Dr Simon Grummet; it was a multidisciplinary meeting to ascertain if the Trust could do anything different. Minor	**SH**

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	changes were made. One discussion took place regarding whether to release some of the breast team from doing other tasks (for example operating) to achieve the two week target. It was decided not to do so, as the patients who are not seen within 14 days are seen within 16 to 18 days, and to divert staff to achieving the 14 day target would have an impact on the other targets including the 62 day one. Once the patient has the initial appointment most patients are seen within the 62 day category. Following a brief discussion, the committee agreed with the decision of the multidisciplinary team. Monthly harm review meetings still continue and GN assured the committee that all staff are doing what they can. **Resolved: Report was accepted**	
4.2	**Board Assurance Framework Key Issues** In the absence of Keith Wilshere, MM advised that at the Finance & Performance meeting earlier they had looked at risks SR8 and SR9 as it was recognised that all of BAF had been updated since the last Trust Board meeting. F&P has asked that the Board reflect on what to do with a strategic risk which has been red for several years, and where the target is going to be red and has been for several years. The Board has to recognise that it is running the organisation with a significant strategic risk. MM asked if the Trust is doing the right things to recognise that it will get better in the short term and make sure that the correct control monitoring and on-going efforts to mitigate it are in place. MM commented that it is useful that the BAF is now focused on four strategic risks. MM noted that a major part of the Trust expenditure is the pay bill and asked if when the controls and gaps are listed if this could include agency, bank, medical fellows etc. This will allow the different categories of pay are all being controlled and monitored in-depth. RE commented that there is plenty of updates on the workforce and updates on SR12. RE enquired about P11 on risk SR12 and mentioned that some of it is positive and some of it is more work needed. MM confirmed that the positive was an external reviewer and the work required was the new recommendations. MM agreed that the wording needed to be changed. RE recommended that the key points from the report which the Trust needs to do more of need to be added to the risk. JO agreed to the changes. RE noted a spelling mistake on risk **SR12** GC4 (previously C11) – collated should read co-located Medical Examiners. **Trust Risk Register – S Hickman (on behalf of M Arthur)** SH presented the Trust Risk Register to the meeting and it was noted: **4 new risks:** **5069 -** Fast Track Capacity (COO) – in relation to fast track demand through the Dermatology Service as it is felt that there is a workforce capacity issue. **5182** - Lack of Network support for Vascular Services at RWT (MD) **5190** - ePMA downtime / outage issues (MD) – this is a system issue and is a joint risk between Pharmacy and IT. **4382 -** NX55 Main Theatres, Wards A12, A14, Admin, Plant Rooms - Fire Safety (COO) – GN advised the meeting that this risk had been sent to herself but had not yet been signed off and is a potential new risk. GN assured the meeting that this risk is actively managed by the Fire Safety Group and she would look into whether it is needed to be on the TRR or could be managed at Directorate / Divisional level.	**GN**

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	0 risks removed **7 red risks:** **2080** - Risk to quality of patient care: reduced manpower (COO) **4661** - Lack of robust system for review and communication of test results (MD) **4472** - Delays in Cubicle Assessment and Triage (COO) **4113** - Division 1 failure to achieve CIP target (COO) **5088** - Fragility of SaTH service (COO) **5182** - Lack of Network support for Vascular Services at RWT (MD) **5190** - ePMA downtime / outage issues (MD) **2 Updated risks:** **4903** – Downgraded from a red to amber **4113 –** Trust instead of Division 1 – SH to update front cover accordingly The meeting was advised that risk **4529** (in relation to vacancies) has now been merged with risk **4565** (agency risk). Actions need to be updated on the TRR and SH will pick this up. MM raised queries about the following risks: **5088 –** MM asked if there was any progress and was advised that there was not and the biggest impact is felt within the Maternity Department. This was discussed further and GN agreed to update as daily telephone calls to NHSI ceased in January. **5182** – MM enquired what a Frozen Elephant Trunk (FET) was and sought an explanation of the risk. JO explained that this Trust is a designated Aortic Centre and does work within the Cardiothoracic Unit. When a patient comes in with an issue with their aorta, this must be treated quickly as there is a high rate of mortality with this condition. Part of this procedure can require replacement of part of the aorta. The Frozen Elephant Trunk is part of a graft and is called so because it looks like an elephant truck. JO explained that a national review is taking place and an organisation is not allowed to be an Aortic Centre if they are not co-located with Vascular Surgery services. Currently this Trust's closest Vascular service is at Russell's Hall, Dudley. If RWT loses its Aortic Centre because of this lack of co-location there will be none in the Black Country. The nearest centres will be in Stoke, Coventry and Birmingham. JO advised that there have been discussions with the CCG and NHSI and the Trust has been encouraged to add this to the Trust Risk Register. The meeting discussed the history of the loss of the RWT vascular service, the service currently provided from Russell's Hall and the need for a solution which takes into account the needs of patients in the Black Country. **5190** – MM raised concerns about the ePMA system freezing and preventing nurses from ticking the drug administration box to indicate that a drug has been administered. JO advised the meeting that it is not known why the system freezes. EMIS and the Trust IT department are working together to go through the system to see if they can ascertain what the issue is. Asked if other trusts have had similar problems he said there is a limited number of Trusts around the country who use this system. **Resolved: Reports were accepted**	**GN**

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5	**Sub Group Reports**	
5.1	**Chairman's Report – Quality & Safety Intelligence Group (QSIG) –** There was no meeting in February due to the number of apologies, February's reports deferred to March's meeting. **Resolved:**	
5.2	**Quality & Safety Intelligence Group minutes**	
5.3	**Chairman's Report – Compliance Oversight Group (COG) – February 2019 – Dr J Odum** The key points noted from the COG Chair's report are: • Pleural Services Group • Pressure Ulcer Report • Point of Care Testing • Organ Donation Group • Medical Devices • Cervical Cytology Screening • Patient Experience Q3 Report The meeting commented on the fantastic work completed by the Organ Donation Group who have achieved a 100% referral rate during a six month period. **Resolved: Report was accepted.**	
5.4	**Compliance Oversight Group minutes – February 2019** MM sought clarification of Pleural Services Group, AMC and JO explained that the nurse is currently waiting sign off. Correction to the minutes for Point of Care Testing: Mandatory Training records are not compliant with Trust Policy. The meeting accepted the minutes from the February meeting.	
6	**<u>Assurance Reporting / Themed Reviews</u>**	
6.1	**Mortality Update Report – Dr J Odum** JO presented the above report. The meeting was informed that the most recent SHMI is 120.3 and continues as a plateauing trend. Work with the Mortality Review Group is on-going and a number of reviews of the alerting diagnoses are on-going. This means that a nominated specialist reviews approximately 30 patient notes and feeds back if he / she is happy with the clinical care and coding. JO assured the meeting that following the reviews the quality of care being assessed is generally good. However, some of the patients are allocated into the wrong diagnostic groups.	

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	JO confirmed that two sepsis lead nurses have been recruited and can begin the actions on sepsis and training staff. For the palliative care team, a consultant is to be recruited. Reviews of high SHMI groups have been completed for Fluids and Electrolytes and for Influenza, and a Pneumonia Audit has been completed. Reviews of Sepsis, Stroke and AKI are in progress, and Congestive Heart Disease is due to start. In ED, the analysis is around how patients are treated when they present with one of these conditions. The Trust has a lot of evidence in regards to the quality of care and JO feels the Trust has the right approach. The Chair of the West Midlands Mortality Group confirmed at a recent meeting that the Trust is doing everything possible with Mortality. JO thought that by taking a range of actions over time, an impact on the SHMI might be observed over the next 12-18 months. JO mentioned that plans are in place with local Trusts who had had experience of a high SHMI to share learning. **Resolved: Report was accepted.**	
6.2	**Terms of Reference – Review and Agree – Chair** The meeting reviewed and asked for a change to number nine – to insert *and annual* ***clinical*** *audit plan ….* **Resolved: Terms of references agreed and to be submitted to the Trust Board for sign off.**	
6.3	**QGAC Meeting Schedule – M Arthur** The schedule was agreed by the meeting. **Resolved: Schedule agreed.**	
6.4	**Information Governance Toolkit Sign Off – Dr J Odum** JO presented the above paper to the meeting. JO explained the new toolkit, Data Protection and Security Toolkit is part of the GDPR and replaced the old IG toolkit. For this Organisation there are 100 mandatory requirements and the Organisation is currently compliant with 86. Work is ongoing with the remaining 14. The likelihood is the Organisation will not submit a fully complaint toolkit at the end of the month. The Organisation will submit with an action plan / improvement plan. JO advised the meeting of the implications of non-compliance. Currently the Trust is unaware of the position of other local Trusts. Kevin Stringer & JO have met with the leads of the standards to ascertain their position. The recommendation is to support the sign off the action plan / improvement plan. MM noted that the Trust is currently asking what is required to meet the compliance and asked that this is noted in the action plan. **Resolved: Agreed to sign off**	
7	**Issues of Significance for the Trust Board** **Advise** BAF: F&P would like the board to reflect on how it is managing risks that have been red a	

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	long time and whose target is a (lower) red, and whether mitigation measures are sufficient. **Assurance** Organ Donation Group report on performance **Partial Assurance** Clinical Audit: systems to identify audits which reveal practices and standards which could impact on strategic objectives (e.g. being in top 25% of performance) are not in place. This means that QGAC are not able to look at the implications of audit findings for quality of care on a prioritised basis. Governance to consider in discussion with Clinical Audit lead what might be done to identify such audits. Mortality: QGAC received two reports, an update and a summary report and reviewed BAF risk SR12. QGAC have asked for reports on Sepsis and on Stroke Services for future meetings. Cancer performance and breast cancer 14 day waits Caesarean Section Audit: QGAC received a report of an audit into caesarean section rates, looking at 687 cases between 1/5 and 30/11 2018. TRR New Red Risk: 5182: Cardiac and Aortic Services not co-located with vascular services COG Chair's report on Point of Care Testing: issues with incomplete transfer of blood gas results to the ICE system in Pathology. Information Governance: QGAC approved a report which said that RWT were not meeting 14 of the 100 hospital standards and were unlikely to achieve 100% by the submission deadline of the end of March. List of actions: I think 7, matters for Audit Committee, has been completed through the report on VTE received at this meeting, so can be closed.	
8	**Evaluation of Meeting – ALL** Interesting discussions	
9	**Any Other Business – ALL** There was no other business to discuss.	
10	**<u>Date and time of Next Meeting</u>:** Wednesday 24 April 2019 **Venue: Conference Room** **Audit Committee: 1pm to 3pm** **QGAC: 3pm to 5pm**	

COMMITTEES ACTION SUMMARY REPORT

ITEM	Action to be taken raised from the meeting	Lead	Committee Date	Review date	Update
4.1 – 20.03.19	When the SJR1 phase and Overall Care Outcomes graph was discussed MM asked if the colour code could be changed and the key to be put into Excellent, Good, Adequate, Poor Care. SH agreed to do this.	SH	20.03.19	24.04.19	
4.2 – 20.03.19	**4382 -** NX55 Main Theatres, Wards A12, A14, Admin, Plant Rooms - Fire Safety (COO) – GN advised the meeting that this risk had been sent to herself but had not yet been signed off and is a potential new risk. GN assured the meeting that this risk is actively managed by the Fire Safety Group and she would look into whether it is needed to be on the TRR or could be managed at Directorate / Divisional level.	GN	20.03.19	24.04.19	
4.2 – 20.03.19	**5088 –** MM asked if there was any progress and was advised that there was not and the biggest impact is felt within the Maternity Department. This was discussed further and GN agreed to update as daily telephone calls to NHSI ceased in January.	GN	20.03.19	24.04.19	
4.1 – 20.02.19	RE queried why on "the % of patients who presented with sepsis to the emergency departments – the target is 90%, the chart indicates red on 45.9% and amber on 52%. AMC will review AMC mentioned that these levels are part of the contract, so the Trust is complying with the contract. RE advised the meeting that she had queried via e-mail if this was	AMC	20.02.19	20.03.19	

	appropriate for a rag rating on performance for Sepsis. AMC replied that a further update will be provided at a future board meeting when the contractual agreements have been finalised. Following an update from AMC, RE asked for a separate update on Sepsis. AMC commented that the two Sepsis nurses have commenced within the Trust and the team is now meeting and an action plan formulated and this will be completed by the end of the month. **AMC is hopeful that a plan will be brought back to a future meeting.**	AMC	20.03.19	**June 2019**	
4.2 – 20.02.19	**Trust Risk Register – M Arthur** MM noted that the description on the summary sheet for risk **4113** is incorrect. GN advised the meeting that the risk has been updated. MA to change to **Trust wide CIP Target.**	MA	20.02.19	20.03.19 24.04.19	MM noted that the risk had been changed however; the front sheet had not been changed. SH to pick up. Bring forward to 24.04.19
7	**Matters for Audit Committee** VTE Audit by External Auditors MM reported that Audit Committee at their December meeting had considered QSIG's request in November for Internal Audit to look at the VTE process. Audit had declined, as there were existing recommendations from External Audit to work through. RE and MM, both on Audit, stressed the importance of RWT being able to demonstrate that it identified all patients who required VTE assessment, and that they received the	~~RE~~ MM / RD	~~23.01.19~~ 20.02.19	~~20.02.19~~ **May 2019**	MM confirmed that this was raised at the Audit Committee and acknowledged that KPMG were the ones to make recommendations to improve the process, they were then going to see what work they could do between now and the year end to see if those were being implemented sufficiently to give a clear opinion when we come to the Quality Report. VTE is being reviewed again. Lengthy discussions took place and assurance was given that work is on-going to try to improve VTE's. RE asked if it would be possible to have a report on what KPMG have found and where the Trust is currently. MM replied that Roger Dunshea to ask for

	assessment at the appropriate times. RE to seek an agenda item on this for the 12 February Audit meeting.	JO	20.02.19	20.03.19	this report. JO to ask Kevin Stringer why VTE was selected again for audit.
4.1 / 21.11.18	GN agreed to review the TRR and consideration to the BAF (Cancer)	GN	21.11.18	~~23.01.19~~ ~~20.02.19~~ ~~20.03.19~~ 24.04.19	GN advised the meeting that she is currently in the process of completing this action and will update at the next meeting. GN to email RE/KW/MM with views to agree reasoning GN confirmed that she has started this work but will circulate prior to her leave. GN confirmed that this is currently a working progress. GN advised the meeting that this is going into a BAF format. Bring forward to April.

Closed Agenda Items – To be removed at the next meeting

ITEM	Action to be taken raised from the meeting	Lead	Carried forward from	Committee Review date	Update
4.1 – 20.02.19	AMC mentioned the late patient moves and noted that 79% of the data are from AMU and feels that this area works 24 hours a day and patient flow through. AMC has reviewed the good flow practice and there is nothing that she can find around the flow management that is showing bad practice. There	AMC	20.02.19	20.03.19	AMC confirmed that the update is in the IQPR and it is split down to: • How many patient moves at AMU • How many patient moves at SEU • How many patients are ward to ward

	were 79 patients that moved ward to ward and AMC mentioned that she has not had chance to review the data but would do. RE queried why AMU was being documented if it was not necessary. AMC agreed to review the data and report back to the meeting.				From the report the meeting noted that 7% of the moves are ward to ward. Louise Berry is conducting an audit in April to ascertain why ward to ward moves are taking place. AMC is to ask colleagues at the CCG if this can be removed from the report. This was discussed further and AMC assured the meeting that she had reviewed the guidance and everything done by this Trust is appropriate. Agreed to close this action.
4.1 – 20.02.19	Complaints have increased in two Directorates (Elderly Medicine and Obstetrics & Gynaecology wards). AMC advised the meeting that the Matron for Elderly Medicine was off this week and AMC would update the Trust Board on Matron's return.	AMC	20.02.19	20.03.19	AMC advised that she has received feedback from Medicine (A7 & A8). There are three discharge issues, a complaint about around prognosis and End of Life Care, complaint in regards to a Social Worker and Home Care. This has been reviewed – close action.
4.1 – 20.02.19	RE asked about the graph which indicates SJR: Divisional Allocation (No) v Completed (September 2018 to December 2018) and asked if the graph needed to be reviewed as the bars from Division 2 Allocated are too high following the change in criteria. The meeting discussed the report in-depth and AMC advised that the contents of the report need to be changed. AMC asked MA to liaise with Lesley Burrows to update the graph and include the new criteria.	MA	20.02.19	20.03.19	Email response to SJR Allocation - 22.02.19.msg Close
4.2 – 20.02.19	AMC offered to speak to Keith Wilshere in regards to the **Board Assurance Framework report**	AMC	20.02.19	20.03.19	Updated - close
6.1 – 20.02.19	GN mentioned that the Volunteers Policy needs to be updated; AMC	GN	20.02.19	20.03.19	GN confirmed that she had spoken to Alison Dowling - CLOSE

	recommended that GN forwards said policy to Alison Dowling copying to Deputy Chief Nursing Officer.				
4.2 / 2301.19	**Risks 5112 / 5116** MM mentioned that she did a walkabout on ICCU in October and the Nurse in Charge was excited about the new staff recruited and how education had developed a two month programme to train the new staff (combination of ward and classroom). MM advised the meeting that she is surprised to see the risk. GN reported that the business case was had not been agreed when MM did the walkabout. The meeting discussed these two risks and it was agreed that GN would review	GN	~~23.01.19~~	~~20.02.19~~ 20.03.19	GN confirmed that risk **5112** has had some updates, around evidence that it is not working (page 41 of the TRR). Dates have been updated but the risk has not been updated but it has been reviewed. GN confirmed that she will ask the Directorate / Division to review the risk. The meeting discussed the risk and issues in recruiting to ICCU Bring forward to March. Risk updated - close
4.1 / 23.01.19	RE asked about the emergency C-section rates which require auditing to determine if the indicators are appropriate. RE noted that the previous QSIG minutes mentioned that the Commissioners have concerns and the Directorate. RE requested the audit results are brought to this meeting, this was agreed. VW to advise the date.	VW	23.01.19	20.02.19 20.03.19	E-mail with update from Vanessa Whatley – The audit summary report to be presented at CQRM in February and QGAC in March. Close
4.1 – 20.02.19	RE queried why on "the % of patients who presented with sepsis to the emergency departments – the target is 90%, the chart indicates red on 45.9% and amber on 52%. AMC will review	AMC	20.02.19	20.03.19	AMC mentioned that these levels are part of the contract, so the Trust is complying with the contract. RE advised the meeting that she had queried via e-mail if this was appropriate for a rag rating on performance for Sepsis. AMC replied that a further update will be provided at a future board meeting when the contractual agreements have been finalised. Following an update from AMC, RE asked for a

					separate update on Sepsis. AMC commented that the two Sepsis nurses have commenced within the Trust and the team is now meeting and an action plan formulated and this will be completed by the end of the month. AMC is hopeful that a plan will be brought back to a future meeting.
4.3 / 19.09.18	**4528** – JS asked if the datix had been updated as it has been on for a long time. GN to chase for an update.	~~GN~~	~~19.09.18~~	~~24.10.18~~	GN advised that this risk had still not been updated – GN to chase for an update and bring forward to the November meeting.
				~~21.11.18~~	To be discussed under TRR – leave action open
				~~23.01.19~~	Risk not updated – agreed to bring forward to next meeting.
		JO		20.02.19	GN asked JO if he would be happy to review the risk for Clinical Web Portal and asked if he feels that this is still a risk. JO agreed to this. JO explained the process of web portal
		MA			MA to see if any datix has been raised.
				20.03.19	GN confirmed that this had been reviewed but the risk had not been updated. There has been one datix incident reported which is waiting for Division 3 Divisional Medical Director's approval and there has been identification that the information in the datix was included in hospital notes but not via the Clinical Portal. Therefore the risk has not been amended as yet.
					Agreed to close