Minutes of the Quality Governance Assurance Committee held on the:

Date **Wednesday 25 January 2017**

Venue **Boardroom, G099, Building 12**

Time **2.00pm to 4.00pm**

	Name	**Role**
Present:	R Edwards **(RE) -** Chair	Non-Executive Director
	Dr J Anderson **(JA)**	Non-Executive Director
	M Arthur **(MA)**	Head of Governance & Legal Services
	C Etches **(CE)**	Chief Nursing Officer
	M Martin **(MM)**	Non-Executive Director
	G Nuttall **(GN)**	Chief Operating Officer
	Dr J Odum **(JO)**	Medical Director
Apologies:	D Loughton **(DL)**	Chief Executive

Item No		Action
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** **RESOLVED: Minutes of the Quality Governance Assurance Committee held on 23 November 2016 were approved as a correct record.**	
3	**Matters arising from the Minutes** The matters arising from the Minutes were updated on the action log sheet and closed accordingly. 4.1 – 23.11.16 – RE asked how the Trust had done on the flu jab; CE reported that 71% of the staff had had their flu jabs prior to 31 December 2016. Unfortunately this meant that the Trust missed the target. CE assured the meeting that a massive effort went into achieving 71% but there was a level of resistance amongst some of the staff. The meeting discussed this further and how to improve the figure next winter. RE noted that following the MRSA case in October and an arbitration meeting between the Trust and the CCG, it was held that it was neither and was a 3rd party. CE confirmed this was correct.	
4	**Regular Reports**	
4.1	**Integrated Quality & Performance Report – November - C Etches & G Nuttall** RE asked if anyone had any questions about the November report that they wished to raise. No one had any questions; however, RE did have several points which she sought clarity on. RE asked what the statement "*CCG have declined the recommended serious incident pathway for pressure injuries in accordance to NHS England recommendations"* meant. CE replied that the CCG are not following the NHS England recommendations, whereas other Trusts are. The Trust would like to come in line with the NHS England pathway but our CCG are saying no. However, there have been 2 meetings to seek to modify the definitions to try and limit reporting to the really serious incidents. RE queried that a number of Urological operations were scheduled in November, with extra Saturday lists continuing through to April next year and asked if this was part of the recovery plan. GN confirmed that the impact is being seen on the time people have to wait to be seen. This impact is not changing the 62 day but it is reducing the number of people waiting a longer time, which is clearly a good thing for the patients. JA queried if there was any evidence of patient deterioration with the length of the wait time and GN replied that a recent	

Item No		Action
	review had taken place and confirmed to the CCG that there had been no deterioration with the patients. RE queried about the evaluating a new mattress with improved heel offloading technology in the Northeast locality and noted that the trial had stopped because a patient had died. RE asked if this was going to be restarted. CE advised the meeting that she would e-mail the meeting once she had obtained the answer.	**CE**
	RE sought clarification over how Community Pharmacy errors were now defined. CE confirmed that there was a pharmacy based within the Community and informed the meeting that there would be a few changes around the Pharmacy reporting and actions following the employment of a new Director of Pharmacy.	
	RE asked when WRAP training would be provided to the Board. CE replied that currently it is for front line staff. All staff need to be trained by the 31st March. The Trust is currently on track to achieve the deadline. Non-clinical staff will be receiving different WRAP training than the clinical staff. CE to confirm when the Board members need to receive their WRAP training by.	**CE**
	Integrated Quality & Performance Report – December - C Etches & G Nuttall CE presented the Quality section of the above report for December. The meeting was informed that the complaints response rates have reached an all-time high at 93%. This is due to the new policy and how people are embracing the new policy in terms of its implementation. However, the Trust is still having a few breaches. During December there are 3 breaches in complaint responses, of these 3, 2 were completed by 31 days and the 3rd took 64 days. CE confirmed that she is still meeting with the teams who do not meet the Trust response target and is asking for a SOP to be developed and a copy is to be provided at a local level. CE reported that there continues to be an improvement across both Divisions for quarter 3 for Family & Friends Test rates and recommendation rates. CE has tasked DH to ascertain what actions we are taking to improve the recommendation rates following the returns of the FFT's. Falls with harms are still a challenge but for the month of December there has been a reduction in the rate of falls. Pressure injuries the Trust is currently seeing reductions in pressure injury and the avoidable falls. CE informed the meeting that the Trust is still currently waiting for the outcome of the TOTO business case submission. CE explained that TOTO is a piece of equipment for patients within the community to give alternating pressure relief. This equipment is expensive and the Trust has to apply to the CCG on a case by case basis. CE informed the meeting that the CCG hire this piece of equipment. CE stated to the meeting that late observations have seen further improvements across Divisions 1 & 2 and is monitored weekly. However, despite the improvements late observations are still not hitting the 5% target. The Trust has breached the C-Diff target; however there was a decline in cases noted for December. CE advised that she has been informed by Dr Mike Cooper that there has been a	

Item No		Action
	reduction in C-Diff since disposable mops and utilising in the correct way have been implemented within the Trust. CE informed the meeting that there has been improvements in children's safeguarding training, however, training within level 2 and 3 have not reached the 95% threshold yet. Midwives are at a 1:30.4 birth ratio and CE informed the meeting that more midwives are set to start with the Trust in January. CE advised the meeting of national and local issues with the Safety Thermometer and informed the meeting that the Trust can survey over 1100 patients in one day.	
	The meeting discussed in-depth E Coli and the target changes to be set by the CCG. Following these discussions it was agreed to include CPE chart within this report.	**CE**
	JA asked about the moderate harm medication incident on page 19 of the report and whether any cross referencing with other incidents e.g. VTEs takes place to identify any that are also medication incidents. It was explained that the RCA carried out should identify such incidents, but to establish how this works in practice. It was agreed that MA would meet the Director of Pharmacy and discuss further.	**MA**
	CE reported that there had been a peak in Radiation Incidents and these were being investigated. RE noted that there had been a rise for the last 3 months and asked what the Trust was doing in regards to the increase. CE advised that each incident is investigated with a RCA and actions associated. Recruitment within the department has improved. RE commented that the regular report to QSAG did not cover lessons learnt from RCAs. CE confirmed that the report does not indicate themes i.e. human errors. RE asked if work could be done to pick out any themes from these investigations and provide a short report. This was agreed.	**CE**
	The meeting commented on the improvements within Maternity. GN presented the Performance section of the report. GN advised the meeting that there was a significant improvement in regards to cancelled procedures. The meeting noted that in November there was an issue with the MRI scanner which resulted in cancelled and reduced capacity. In December there was an improvement but an issue arose with the CT scanner. Throughout January work is on-going to ensure additional capacity is provided. GN reported that there is a reduction in overall A&E attendances to date in January. GN is unsure whether the media message about not attending A&E is getting through to the public and deterring the public from attending. However, ambulance activity is increasing. The meeting discussed the service 111 and the effect on ambulance call outs. GN gave a brief overview of attendances at Vocare. JA asked if the delay in finding the patients cubicles and triage had resulted in any patient harm. JO replied that we do not have any evidence in house that we have caused harm with the delays. However, the national evidence is that delays do cause harm.	

Item No		Action
	Emergency admissions via ED showed an increase in % and numbers in November and December. GN though the increased numbers were seasonal. The meeting was notified by GN that Urology's performance on 62 day target by cancer site is improving. GN informed the meeting that she has asked for a deep dive into New Cross Theatre activity for Ear, Nose & Throat following a significant dip in November and December. The meeting was advised that during the Finance & Performance meeting earlier in the day a brief discussion took place regarding delayed transfers of care. The main issue with the delays is down to Social Care. GN explained the new process to the meeting. JA raised concerns about the number of staff currently off work with anxiety, stress and depression. JA asked if there were any new initiatives in order to try and reduce the number of staff off sick. CE advised that if the Director of HR was in attendance she would probably advise that the figure was not work related stress. **Resolved: Report was accepted**	
4.2	**Board Assurance Framework / Trust Risk Register – M Arthur** MA referred to the last Quality Governance Assurance Committee minutes concerning the suggestion at Finance & Performance to change the rating of **SR6** from amber to red and to raise the score of two red risks, **SR8** and **SR9**, the proposal was going to be discussed at the November Trust Board. Having received to date no feedback, MA asked if there had been any discussion. MM advised that it had been discussed again at Finance & Performance and the risk holders have decided not to change the rating at the moment. MA advised the meeting of the following Board Assurance Framework and Trust Risk Register points: **Board Assurance Framework Key Issues** **0 new risks.** **5 red risks**: **SR1** - Workforce - Recruitment and Retention of staff across the Trust and in particular the future pipeline of nursing and medical staff **SR4** - Risk of adverse impact on the Trust following service transfer in November 2014 due to underlying financial gap of £6million **SR8** - That there is a failure to deliver recurrent CIP's. **SR9** - That the deficit plan for 2016 is not achieved and the medium term financial plan fails to bring the Trust back to surplus. **SR10** - That the Trust fails to generate sufficient cash to pay for its commitments.	

Item No		Action
	Trust Risk Register Key Issues **3 new risks:** **4616** – Safeguarding risk due to a backlog and inadequate filing of Antenatal Summary Tracer Cards (COO). JA and MM questioned whether if 80% of the backlog had been filed why would it take 6 months to complete the job. GN was sure this was nearly complete and thought the 6 months referred to the original date this risk was put on the risk register. JA asked if this had been on the Directorate and Divisional risk register. GN said it had been identified during a CCG quality visit. The Division had not recognised the level of risk the backlog posed. JA pointed out there was no date of origin or escalation on this risk and on a number of other risks and asked that this information be provided again in future. **4696** – Unreported Imaging Studies (COO). JA asked about the skills of Clinical Fellows and how they are supervised. JO said Clinical Fellows join us as competent staff and their level of competence and level of supervision needed is assessed by the Clinical Director. JA asked if this risk was on the Directorate Risk Register. JO said it was known, but had not been put on the Risk Register. MA commented that directorates need to be able to recognise the potential risks of a set of circumstances. **4650** – CICT Model change (COO). GN explained that a change in the way LA staff were deployed, having moved out of a joint RWT/LA team, had resulted in delays in discharges. **3 risks removed:** 4545 - Demand Outstrips Capacity for MRI scanning (COO) – downgraded to yellow – Directorates Risk Register. The consultant gap that was had is now being covered by agency. 2781 - Contractual risks due to tariff changes for emergency threshold (CFO) 4581 - Fines for contract performance (CFO) **4 red risks:** 4161 - Shortage of Qualified Nurses across the Division (COO) 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) Risk **2680** translation budget. MM questioned why this was classed as a risk. The budget was quite small, it was always exceeded, but this did not warrant it being on the TRR. If we implemented changes to hold the costs within budget or to reduce the budget, using approaches adopted by other Trusts, that might constitute a risk that might need to be on the TRR. CE said she would take the issue away for further consideration.	**MA** **CE**
5	**Sub Group Reports**	
5.1 & 5.2 **5.3**	**Patient Safety Improvement Group minutes – November & December – C Etches** The meeting accepted the minutes from the November & December meetings. **Chairman's Report - November** **1. Resuscitation Group - Arrest trolley audit** Due to concerning results a pilot of "double checkers" for trolleys has been implemented. Audit of the adult trolleys will take place in January 2017. The new approach has been supported at	

Item No		Action
	a Divisional level. A reduction in the number of trollies to be checked may alleviate the time being utilised for this task. The paediatric audit is due in May 2017. **2. New procedure – Non-medical Endoscopy** This procedure was approved. Governance arrangements were provided and also arrangements for medical back up, should it be required, are in place on both RWT and Cannock Chase Hospital sites. The endoscopy practitioner role and scope of practice was clearly understood at the meeting. **3. Ward Performance Report** Falls – neither Division is seeing an overall decrease in the number of falls and therefore falls with serious harm too. Future reports will identify the latter separately. A review of decant arrangements has taken place. Following a fall incident changes have been implemented. **4. Safer Surgical Checklists** Overall compliance is good; however, discussions took place regarding quality assurance processes for reassurance that 100% or "green" really is that. Division 1 is looking at the potential use of a "mystery shopper" model. Division 2 had identified a theme of non-completion of forms where locums had been employed. This needs to be reinforced at induction of temporary staff with regards to Trust policy and practice. **5. Medication Safety** The Medication Safety Officer (MSO) has developed a medication safety dashboard. Electronic data capture of pharmacist intentions is being trialled. The new Chief Pharmacist will be supporting the quality and content of future medication reports and the governance around this. PSIG will review the new model of reporting for its effectiveness.	
5.4	**Chairman's Report - December** **1. SUI's** There are a number of outstanding actions for both Divisions not completed by their original date. Clarification was sought as to the process for monitoring actions. Agreed that realistic timeframes need to be established. Monthly meetings not working; both Divisions to review the frequency and also include in the report the length of time the action was outstanding. **2. Audit of Aortic Valve** Report on the aortic valve repair programme was presented. The MDT approach to decision making and operating was commended. Consultant stated that the Proctor involvement in the decision making was very important. As yet there is no published data in the U.K. but the department results compared well nationally. The team wish to continue with the procedure with the current arrangements and establish RWT as a Centre.	

<table>
<tr><th>Item No</th><th></th><th>Action</th></tr>
<tr><td></td><td>3. <u>Patient Experience</u>

The progress being made with the development of the report and more importantly the actions contained within, was noted. Noted report will include friends & family for children and there with be more information on the feedback cloud. The Q3 patient experience report will include corporate and directorate actions cited.

4. <u>OP10 Risk Management & Patient Safety</u>

It was noted that this report aligned with the conclusion of the Deloitte and other external review on the Trust risk management process. Systems and processes are good/sound, however, there is room for improvement. Audit demonstrated some differences between directorates in the depth of the risk register, action tracking and incident reporting. An action plan was presented with minor changes to the plan – but continued focus from the Divisions.

5. <u>Transfer & Discharge Audits</u>

Historic audit of Trust transfer and discharge has been poor. This audit showed an improvement, however, there was considerable discussion about what we should actually audit. Further update was requested in January 2017 to ensure this was relevant and meaningful and would have a positive outcome for staff and patients.

6. <u>Mortality Report</u>

Noted that the standardised published mortality rate is increasing and there is a consistent trend. Investigation points to changes in data, rather than a spike in mortality. Assurance was received that the Trust's mortality groups were focussed and robust in their investigation and challenge when reviewing mortality. Reported was noted.

Resolved: Report was accepted.</td><td></td></tr>
<tr><td>5.5 & 5.6

5.7</td><td>Quality Standards Action Group minutes – November & December – Dr J Odum

The meeting accepted the minutes from the November & December meetings.

Chairman's Report - November

1. <u>Quality Review Visit Surgical Emergency Unit</u>

An update was provided regarding the QR visit to the surgical emergency unit undertaken in June 2016. Work continues to ensure compliance against the action plan constructed against the recommendations made by the visiting team. A further review visit to SEU will be factored into the QRV schedule for 2017.

2. <u>QRV/Ward West Park Hospital</u>

The QRV was undertaking during August 2016 and the ratings by the visiting team were as follows: safe – requires improvement; effective – good; caring – outstanding; responsive – outstanding; well led – requires improvement.

Again, the QRV had been undertaken well and the recommendations made received positively by the ward/staff. A number of issues were picked up by the visiting team leading to the</td><td></td></tr>
</table>

<table>
<tr><th>Item No</th><th></th><th>Action</th></tr>
<tr><td></td><td>recommendations but it was noted there is now a new ward manager in place who was leading the changes required.

It was agreed that a review visit would be factored into the QRV schedule for mid-2017.

3. <u>Wolverhampton Cervical Screening Programme</u>

Dr A Bhatnagar presented an update regarding compliance with the requirements set out for the cervical screening programme, as the lead for the programme. Compliance with the individual performance targets that are monitored is excellent and the group thanked Dr Bhatnagar for the enthusiasm and performance which she has brought to the programme over the last 3 years as the lead. Dr Bhatnagar has now stepped down from the post and has been replaced by Roy Cooper, Head of Bio Medical Science.

4. <u>CQC Compliance Internal Self- Assessment Report</u>

This report was presented and discussed and it was agreed by the group that a 6 monthly report would be taken to QSAG and then directly to Trust Board. It was specifically agreed that the report would not go to QGAC or Executive Directors although the QSAG report is available to QGAC through routine reporting of QSAG. The decision was made in the interests of preventing duplication of reporting and discussion.</td><td></td></tr>
<tr><td>5.8</td><td>Chairman’s Report - December

1. <u>NCEPOD Treat the Cause (Acute Pancreatitis)</u>

The recommendations made in the NCEPOD report published in June 2016 were noted with the Trust being compliant with all the recommendations expect three as follows:
a. The Trust currently does not have capacity to undertake cholecystectomy within the time frames recommended within the report. This will be escalated to the surgical directorate risk register.

b. The Trust does not have a 7 day alcohol specialist service available and will not be compliant with this recommendation. The directorate view is that specialist alcohol advice being available 5 days per week is satisfactory for this group of patients.

c. The Drug and Alcohol Liaison Team will be asked to review all patients with alcohol associated pancreatitis during their index admission.

2. <u>Trauma Governance Committee</u>

Areas where the Trust is non-compliant with requirements mandated by the West Midlands Trauma Network and detailed in the trauma inspection report are as follows:

a. Patients presenting to ED with major trauma should have a full body CT scan within 60 minutes of presentation, and the report should be available within 60 minutes of imaging being undertaken. An audit into compliance with this requirement is currently in place.

b. Patients presenting with an injury severity score (ISS) greater than 8 should have a full body CT scan. A recent audit has shown poor compliance with this standard (undertaken retrospectively) and ensuring such patients receive the appropriate CT imaging will be escalated through the department.</td><td></td></tr>
</table>

Item No		Action
	3. Internal Quality Review Visit Report – C24 (Sept 16) The detail of the above QRV was presented by the Matron leading the team visiting C24. The ratings for the visit were as follows: safe – requires improvement; effective – good; caring – good; responsive – good; well led – good. Several of the good recommendations were bordering on outstanding and the requires improvement bordered on good. The visit was again, helpful to the area being visited and informative to the team undertaking the visit. The ratings were accepted by the C24 team and actions are in place to address the recommendations made by the visiting team. **Resolved: Report was accepted.** RE commented that all of the chair's reports were excellent and to the point.	
5.9 **5.10**	**CLIP Group – M Arthur** The meeting accepted the minutes. Concerns were raised regarding the delay in the CLIP minutes and Chair's report in coming to this meeting. Following discussion it was agreed that CLIP minutes and Chair's report would come to the next QGAC meeting following the quarterly CLIP meeting. MA advised the meeting that in November 2016 Paul Archer took over as Chair of this Group. **Chairman's Report** **Review of Adverse Incidents** The numbers of adverse incident reported were up from 1272 to 1296 between the two reporting quarter periods. Areas identified included treatment/procedures. Patient health & safety, staffing and medication errors. Whilst there was an increase in overall numbers there was not a corresponding increase in the level of harm being reported. **Information Governance (IG)** The number of IG incidents being reported has fallen slightly. But given the Trust approach to improve IG and highlighting the need to report breaches in standards, irrespective of the level of seriousness, it is expected that numbers of reports will increase. **Root Cause Analysis Reviews** An increase in the number of serious incidents reported relating to delayed / missed diagnosis and treatment delays was noted. The Maternity Unit were now reporting NPSA 2 or 3 only incidents via Steis and that this was in line with other maternity units within the region. These incidents will be subject to a 48 hour investigation / Full Root Cause Analysis. All local action plans are now in place and implementation is monitored on a weekly basis. A brief overview of lessons learned was given, as an example: • Update policy to state that Naso-Gastric Tubes should not be placed out of hours, unless a clinical emergency (148617) • Need for full survey/exam in patients with communication difficulties as history cannot be relied on (149740) • Ensure all staff understand the serious impact of Information Governance breaches through staff and governance meetings (148344) • Update the document "Roles and responsibilities of Junior Doctors working in the acute	

Item No		Action
	medical specialties" to expand on the "Incident Reporting" section to include common types of incidents relevant to medical care. (155374) **Litigation** The overall number of clinical negligence claims received had fallen although the numbers received specifically for Trauma Orthopaedics and A&E had shown a slight increase. Whilst there was also a decrease in the number of personal injury claims received the number categorised as slips, trips and falls had increased. At the time of the CLIP meeting none of the cases reported to the Coroners Court had resulted in adverse decisions being made. NHSLA benchmarking shows the Trust to be: a) Clinical negligence to be below member average, above national and regional average, b) Personal injury to be above member, national and regional average for the reporting period. **Complaints / PALS** Slight increase in the numbers of complaints reported between quarters, the three most reported categories include general care, delay and discharge. The numbers of complaints completed within agreed timeframes continues to increase and this trend is expected to continue. Three complaints were referred to the Ombudsman, 1 being partially upheld, 1 not upheld and 1 awaiting decision. **Other issues** Discussions were held on changing the terms of reference and membership to enable a shift away from performance management to focus on identifying and implementing lessons learned – this to be the overarching focus of the group. It was agreed to invite an IT representative as required and the author of the Risky Business staff newsletter to ensure major issues identified are communicated effectively. Performance information to be included in a dashboard and reported by exception. The group are also looking to develop a lessons learned strategy to focus attention, target learning and communication. **Resolved: Report was accepted.**	
6	**Assurance Reporting / Themed Reviews** There were no assurance reporting or themed reviews for January.	
7	**Issues of Significance for Audit Committee –** Possible future audit of how medication errors are or can be cross-referenced to SUIs. Issue to be first discussed with new Director of Pharmacy. **Issues of Significance for Trust Board –** • Integrated Quality and Performance Report • BAF/Trust Risk Register • Patient Safety Improvement Group – November • Patient Safety Improvement Group – December • Quality Standards Action Group – November	

Item No		Action
	• Quality Standards Action Group – December • Complaints Litigation Incidents & PALs August 2016	
8	**Evaluation of Meeting – ALL**	
9 **9.1**	**Any Other Business – ALL** **2017 QGAC Report Schedule** RE asked if herself, MA and CEm could meet up outside of the meeting to discuss the schedule. MM asked if the Group minutes could be for information only and the Chair's reports are discussed. This was agreed.	**CEm** **CEm**
10	**<u>Date and time of Next Meeting</u>:** **Wednesday 22 February 2017 2pm, Boardroom, G099, Building 12, Corporate Services Centre**	

COMMITTEES ACTION SUMMARY REPORT

ITEM	Action to be taken raised from the meeting	Lead	Committee Date	Review date	Update
4.1 – 25.01.17	RE queried about the evaluating a new mattress with improved heel offloading technology in the Northeast locality and noted that the trial had stopped because a patient had died. RE asked if this was going to be restarted. CE advised the meeting that she would e-mail the meeting once she had obtained the answer.	CE	25.01.17	22.02.17	
4.1 – 25.01.17	RE asked when WRAP training would be provided to the Board. CE replied that currently it is for front line staff. All staff need to be trained by the 31st March. The Trust is currently on track to achieve the deadline. Non-clinical staff will be receiving different WRAP training than the clinical staff. CE to confirm when the Board members need to receive their WRAP training by.	CE	25.01.17	22.02.17	
4.1 – 25.01.17	The meeting discussed in-depth E Coli and the target changes to be set by the CCG. Following these discussions it was agreed to include CPE chart within this report.	CE	25.01.17	22.02.17	

4.1 – 25.01.17	JA asked about the moderate harm medication incident on page 19 of the report and whether any cross referencing with other incidents e.g. VTEs takes place to identify any that are also medication incidents. It was explained that the RCA carried out should identify such incidents, but to establish how this works in practice. It was agreed that MA would meet the Director of Pharmacy and discuss further.	MA	25.01.17	22.02.17	
4.1 – 25.01.17	CE reported that there had been a peak in Radiation Incidents and these were being investigated. RE noted that there had been a rise for the last 3 months and asked what the Trust was doing in regards to the increase. CE advised that each incident is investigated with a RCA and actions associated. Recruitment within the department has improved. RE commented that the regular report to QSAG did not cover lessons learnt from RCAs. CE confirmed that the report does not indicate themes i.e. human errors. RE asked if work could be done to pick out any themes from these investigations and provide a short report. This was agreed.	CE	25.01.17	22.02.17	
4.2 – 25.01.17	**Risk 4616 -** JA pointed out there was no date of origin or escalation on this risk and on a number of other risks and asked that this information be provided again in future.	MA	25.01.17	22.02.17	

4.2 – 25.01.17	Risk **2680** translation budget. MM questioned why this was classed as a risk. The budget was quite small, it was always exceeded, but this did not warrant it being on the TRR. If we implemented changes to hold the costs within budget or to reduce the budget, using approaches adopted by other Trusts, that might constitute a risk that might need to be on the TRR. CE said she would take the issue away for further consideration.	CE	25.01.17	22.02.17	
9.1 – 25.01.17	RE asked if herself, MA and CEm could meet up outside of the meeting to discuss the schedule.	CEm	25.01.17	22.02.17	Meeting took place, new schedule to be circulated at February meeting.
9.1 – 25.01.17	MM asked if the Group minutes could be for information only and the Chair's reports are discussed. This was agreed for the agenda to be updated..	CEm	25.01.17	22.02.17	Completed - CLOSE
4.1 – 26.10.16	JA asked if it would be possible for a metric to be added to the report indicating short to long term sick. CE to ask Linda Holland if this can be done.	CE	26.10.16	~~23.11.16~~ ~~25.01.17~~ 22.02.17	CE has spoken to Linda Holland. CE informed the meeting that the Policy is changing in regards to the definition of long term / short term sickness. Currently there is no methodology in collating this information but this is being reviewed. After discussion it was agreed to keep this item on the action report until January. CE asked if this action could remain on the log as there is still no methodology on how to do it. The meeting agreed.

4.1	CE informed the meeting that there appeared to be a technical issue with the Friends & Family response rate system via texting. CE to follow this up and report back at a future meeting	CE	21.09.16	~~26.10.16~~	CE reported that the issue is worsening and she has asked Alison Dowling & Debra Hickman to speak to the company. CE reiterated to the meeting that the data currently showing on the report is not reliable. Bring forward to the November meeting for an update.
				~~23.11.16~~	CE informed the meeting that a meeting with the company had taken place and the issue has not gone away completely. A proposal to TMC to change the system completely has been submitted for Friday.
		CE		~~25.01.17~~ 22.02.17	CE informed the meeting that last month the data had shown an improvement. However, there are still inaccuracies particular within Maternity Services. CE confirmed that the Trust is aware that their responses are not being reflected in the figures coming back to us. That is still on-going with the company that we use. JA asked the meeting if the graphs could show how many responses are received in figures i.e. is it 6 people or is it 67 people. CE reported that currently assurances cannot be taken from the current information. **The meeting asked CE to ask the company who collates the information how many other hospitals they support.**

6	RE queried the action due date of the Water Safety being 30 December 2018. PA to take this back to MS for clarification.	PA GN	21.09.16	~~26.10.16~~ ~~23.11.16~~	CEm informed the meeting that she would update this action via the minutes – this was agreed. *Margaret,* *The date is a typo, Should read Dec 2017. Reason funding implications.* *Regards* *John* *John Iredale | Estates Compliance Manager | The Royal Wolverhampton NHS Trust, Estates Management, Zone C, Location C27, Hollybush House, New Cross Hospital, Wednesfield, Wolverhampton, WV10 0QP* ☎:*01902 444957* | 07798698922 : ***john.iredale@nhs.net*** The meeting discussed this item and considered that even the amended date for completion of the actions in the Water Safety action plan, December 2017 appeared a long way off, given the priority given to this issue. DL and CE assured the meeting that there are regular water checks and any issues are raised with themselves immediately. GN agreed to find out more about the action plan and the timetable for completion and how this affects water safety.

				~~25.01.17~~ 22.02.17	GN asked for this item to be brought forward to the next meeting.

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
6 – 23.11.16	MM raised concerns about **EV191** dated 03 April 2014. Following discussion, MA agreed to send this back to Directorate for clarification on the date and if applicable update to the action.	MA	23.11.16	25.01.17	MA confirmed that the date of the review is correct and the update received is the final business case has gone through TMC recently so they are looking to appoint to a 3rd Consultant and Surgeon. So that should elevate problems they were having. CLOSE