Minutes of the Quality Governance Assurance Committee

held on the:

Date **Wednesday 30 May 2018**

Venue **Room 6, WMI**

Time **2.00pm to 4.00pm**

	Name	**Role**
Present:	R Edwards **(RE)** - Chair	Non-Executive Director
	M Arthur **(MA)**	Head of Governance & Legal Services
	A M Cannaby **(AMC)**	Chief Nursing Officer
	G Nuttall **(GN)**	Chief Operating Officer
	Dr J Odum **(JO)** (part meeting)	Medical Director
	J Small **(JS)**	Non-Executive Director
Apologies:	D Loughton	Chief Executive
	J Vanes	Chairman

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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 – Joint Audit Committee** Following the Audit Committee on 25 May 2018 a request was made to remove the word "but" from page 5, section 5.4 ***External Audit Interim Report – David Sharif (KPMG)*** *Quality Accounts – DS mentioned that testing had been completed around C-Diff and VTE and there does not seem to be an indication that the outcome of KPMG's work will result in anything different to what the Trust had last year. However, there will be some potential recommendations to the Trust. Understanding is being sought on the context of some of the Trusts controls and procedures around following up VTE patients particularly those who have not had their VTE assessment on admission but within 24 hours.* This was agreed by the QGAC meeting. **RESOLVED: Minutes of the Joint Audit Committee held on 25 April 2018 were approved as a correct record.** **Minutes of Previous Meeting - Quality Governance Assurance Committee:** **RESOLVED: Minutes of the Quality Governance Assurance Committee held on 25 April 2018 were approved as a correct record.**	
3	**Matters arising from the Minutes** The action log was updated accordingly.	
4	**Regular Reports**	
4.1	**Integrated Quality & Performance Report – April – AM Cannaby** AMC presented the quality section of the report. The meeting was informed that complaints have reduced slightly. There were 28 complaints in April compared to 36 in March. Work has commenced with the nurses in regards to Friends & Family rates and how the	

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	figures can be improved. There is an improvement with the response rates but not with recommendation rates. AMC informed the meeting that Alison Dowling and the Matrons are looking at new ways to improve the figures for example by using IPads. Volunteers will be asked to speak to patients to complete the response rates. Division 2 is showing an improvement within late observations recorded. The meeting noted from the reported that the Head of Nursing for Division 2 had implemented a robust 4 week action plan for April and this has resulted in zero red wards for the first time in a year. RE asked if this action plan was sustainable and AMC confirmed that conversations are taking place and will be reviewed in a couple of months. AMC will be speaking to the Heads of Nursing shortly to discuss late patient moves after 10pm. Outliers will be identified with the Outpatient Flow Team and discussions will take place to create an action plan. There was nothing of significance to report on the Safety Thermometer. Levels of acquired Pressure Sores have been sustained over the last 3 months. There will be a greater focus on Community Pressure Sores and also equipment. Major changes will be made over the next few months. There is nothing to report with patient falls; however, work is increasing with patient falls. For April, VTE has seen a drop in compliance; this is due to the new process and new timeframe. This will be monitored over the next month to see if this rectifies itself. April saw a good news story for Infection Control and is currently being monitored nationally. Ward cleaning processes are currently underway. AMC reported that she does not have any major concerns in regards to Medication Incidents. The meeting noted from the report that there was a spike in April with Radiation incidents. This increase is due to issues within Radiotherapy and Radiology. RE advised the meeting that she felt assured by the process picking up these errors. AMC advised the meeting that work was taking place in regards to Safeguarding mandatory training. The meeting was notified that over the next 8 weeks work will be taking place to ensure that staff are in the correct groups and this will then be closely monitored by the Trust and the CCG. This was discussed further with assurance offered to the committee by AMC. A report on Emergency C-Section rates was offered for the July or September meeting. AMC said there would be an external review of maternity services, as this is good practice, and will form part of a series of reviews of RWT services. She said she expected it to be underway in the next couple of months and that the internal report QGAC has sought will be useful material. The meeting agreed to ask for a report for the July meeting. GN presented the performance section of the report. GN advised the meeting that the Performance section of the report was discussed in detail at the Finance & Performance earlier in the day. It was noted that there was an improvement in cancelled operations in April, a reduction from 51 in March to 13 in April and will be continued into May.	

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	Trust waiting times for 18 weeks – incomplete is red at 90.38%. The meeting was advised of the significant increases in the type 1's due to the winter pressures. GN brought the meeting's attention to issues within the Cancer target compliance and concerns were raised regarding the figures. GN advised the meeting that the challenges are with the 2 week wait and 2 week wait breast symptomatic. GN informed the meeting that the issues from April have continued into May. JS queried if this was following the impact of the Primary Care campaign, GN confirmed it was. Nationally March and April have been difficult for 2 week waits. RE asked how much the demand had increased by and was informed by approximately 30%. GN assured the Committee that a weekly meeting is held where all patients on the 62 day pathway are reviewed. The Cancer Intensive Support Team will be in the organisation next week and will review challenged / complex pathways in regards to capacity. It was noted that at the early meeting of Finance & Performance, Simon Evans presented a new cancer dashboard that has been developed in house and will help to track the Trust performance. This was discussed at length and it was agreed to invite Simon Evans to the June QGAC to present this dashboard. GN advised the meeting that the IQ&P report now includes the Planned Care / Vertical Integration information. The meeting noted that these metrics required further work to give the board an indication of whether significant risks in VI were being managed; that the previous metrics for community care had been removed, that they had not been of much help to the board, and that there was a need to develop metrics in community care which did help. The meeting agreed that this was an area of work-in-progress, and that they would be paying it particular attention. **Resolved: Report was accepted**	**CE**
4.2	**Board Assurance Framework / Trust Risk Register – M Arthur** MA presented the BAF and TRR papers to the meeting. **Board Assurance Framework Key Issues** The meeting noted that there are now 5 risks on the BAF. **0 new risks.** **2 risk closed:** **SR4** (Risk of adverse impact on the Trust following service transfer in November 2014 due to underlying financial gap of £6million) **SR10** (That the Trust fails to generate sufficient cash to pay for its commitments) have been amalgamated into risk SR9. **3 red risks**:	

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	SR1 - Workforce - Recruitment and Retention of staff across the Trust and in particular the future pipeline of nursing and medical staff. **SR8** - That there is a failure to deliver recurrent CIP's. **SR9** - That the underlying deficit that the Trust has (in 2017/18) is not eliminated in medium term to bring the Trust back to financial surplus. **Updates on BAF:** MA gave a brief update on each risk **SR1 -** There has been some updates and changes to the actions. **SR6b –** That is sustained and reduced last month to yellow. There are no other changes to this risk. **SR8** – Remains a red risk. **SR9 –** Remains a red risk – negative assurance added to this risk that the Trust may not be able to deliver the commissioned activity and work is currently on-going. SR4 was merged into SR9. **SR11 –** Negative assurance added to this risk. The capital programme presented to the Trust Board in April may be under threat if the CRL is not approved by NHSI. This report was discussed at the Finance & Performance meeting. **Trust Risk Register Key Issues** **2 new risks:** **4761** - Cardiothoracic Surgical / Anaesthetic vacancies (COO) – this risk is well populated, actions are within date. There have been no incidents reported against the risk. **5017** - Unable to achieve the activity levels (CFO) – this is an amber risk and has been populated. Controls need to be added in on how to manage the risk. **1 risk removed:** **1714** - Failure of other agencies to support discharge process resulting in delayed hospital discharge (COO) – deescalated to Division 2's risk register. **5 red risks:** **2080** - Risk to quality of patient care: reduced manpower (COO) – this risk was discussed earlier in the meeting. Risk has been updated and work is in progress. **4661** - Lack of robust system for review and communication of test results (MD) – discussions are happening and there is a quick turnaround progress with this risk. **4472** - Delays in Cubicle Assessment and Triage (COO) – positive assurance and the opening of a third room to manage the capacity through the cubicles have shown some improvement. New actions have been added to the risk, matrix developed within Emergency Department and monitoring of the assessment area. .	

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	4113 - Division 1 failure to achieve CIP target (COO) – noted that the figure under *Evidence that it is working*, number 6 is £0 – figure to be confirmed. **4903** - Risk of non-compliance with Thoracic Service Specification (COO) – GN confirmed that the risk will be updated as the position has been appointed to. The meeting discussed the TRR and the following queries were raised: **4862 –** Neonatal cots – RE asked if the business case for additional staff had been approved at the April TMC, GN confirmed that it had and the department are out to recruitment. RE asked for the action regarding comment commencing *There are ongoing incidents relating to the lack of clinical equipment etc*, GN agreed to review this. **4718** – Shortage of staff in the Safeguarding team – JS queried if a named midwife had been identified. AMC confirmed that this was going out to advert; the job description has been agreed. The issue has been resolved but currently there is no-one in post. **4962 –** Workforce establishment on the Neonatal unit not being funded to meet BAPM standards – JS asked if the 102% under *Evidence that it is working* could be refreshed. GN confirmed that it had been updated. **3069** – Never Events within the Division – JS asked if this risk had been updated to reflect the meeting with the CCG in April. AMC to update. **Resolved: Report was accepted**	**GN** **AMC**
4.3	**NPSA NRLS Organisational Feedback Report – M Arthur** MA informed the meeting that this was the 6 monthly report from NRLS indicating how this Trust compares to others. MA gave a brief presentation of this report and it was agreed that this report is easier to follow than previously and the position of the Trust was positive and encouraging. Prompts are given on the report as to what action should be considered. MA advised the meeting that pressure ulcers were missing from figure 5, Sukhbinder Khunkhuna to review.	
5	**Sub Group Reports**	
5.1	**Chairman's Report – Quality & Safety Intelligence Group (QSIG) – April 2018 – A M Cannaby** **COG items for escalation highlighted:** Requested attention by Divisions/Directorates to longstanding external review actions that remain open (2014, 2016 dates) Other items from COG were being addressed within agenda reports **Divisional Integrated Governance Report and Data Pack**	

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	1. ICCU – Review the increase in cancelled elective cases and feedback in May 18. 2. An increase in Medication incidents in **Division 1 (in Feb 18)** is to be reviewed for feedback in May 18. 3. The issue of overdue actions reported from SUI's and other items in the data pack eg external reviews, Health and Safety etc were highlighted for the attention of both Divisions. **SUI Report:** Divisions to review outstanding SUI actions with a view to rationalising what is needed/or to close; and to carry out theming of actions for commonality. **NatSips Audit reports:** Reports were received from Care of the Elderly (CoE) and Urology OPD. CoE reported positive assurance on safety and needed to take forward actions around the consent and patient information leaflets for elective Lumbar Puncture. Urology OPD reported positive results but audit sample size was small, therefore was asked to provide re-audit results in 6 month. **Quality Review Visit D7** The report presented multiple issues from different staff disciplines including documentation completion, use of stamps and the absence of standard ward rounds due to multiple specialty outliers on the ward. The issue of the knowledge, skills and training of D7 (Gynae) ward staff to manage multiple specialty patients was highlighted and consideration of training needs and support was to be given. **Resolved: Report was accepted.**	
5.2	**Quality & Safety Intelligence Group minutes – April 2018** The meeting accepted the minutes from the April meeting. RE commented on the quality of the minutes, stating that they were very helpful and gives a good insight to the meeting. AMC confirmed that she is happy to stay with the new format of the meeting.	
5.3	**Chairman's Report – Compliance Oversight Group (COG) – April 2018** In the absence of JO the meeting held a brief discussion on this report and the minutes. **1. <u>Trauma Governance Group</u>** Whilst there has been an improvement in compliance against the performance standards with respect to Trauma governance, two specific areas require a focus of attention, as follows: • Patients with an ISS (injury severity score) greater than 15 to be seen by a Consultant within 5 minutes of arrival in ED. At present only 3.7% of such patients are assessed within this timeframe, compared with the Trauma Unit average of 14%. Improved triage and utilisation of a "Trauma documentation booklet" will improve compliance. • Time to CT scan for head injury patients should be less than one hour. However, the Trust	

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	scores 33.3% compliance against the Trauma Unit average of 60%. The protocol for Trauma CT scans has now been agreed with the CD of Radiology and following this protocol, should enhance compliance. The Trauma Governance Lead will meet with the CD and Clinical Lead of the Emergency Services to discuss both of the above. **2. Organ Donation Six Monthly Report** For the financial year 2017/18, the Trust achieved 100% referral rate for potential organ donors (DBD/DCD) – a total of 9 patients. Seven of these patients proceeded to become actual organ donors, which is a significant improvement over previous recent years. The improvement is due to a change in leadership and teamworking and also a revised organ donation structure. **3. VTE Prevention & Treatment** Compliance for VTE prevention and treatment assessments for patients admitted to the Trust is set at a minimum of 95%. Historically, the Trust reported compliance data for patients who received their VTE assessment at any stage following their admission. From April 2018 it has been agreed to report compliance against only those assessments made within 24 hours of admission. The Trust is to ensure assessments are undertaken across all admission portals/areas to maximum effect, including the use of the Maternity Badger system to enable electronic capture of ED assessments in Maternity. In addition, the VTE assessments have been extended to include 16-18 year olds. Previously, the cohort only included the patients 18 years of age or older. The impact of this new change is uncertain. **4. Hospital Transfusion Group Report** Mandatory Training compliance for transfusion is currently at 90.4%. Notably, whilst all staff have access to the national e-learning package a more "user friendly" bespoke local e-learning training package has been developed, which may facilitate improved compliance figures. Generally, performance relating to transfusion matters is very good across the organisation. Of note, there were 11 SHOT reportable incidents reported between 1st October 2017 – 31st March 2018, three of which were in obstetrics (low grade) including two anti-D treatments given to the wrong and/or inappropriate patients. **5. Equality Diversity & Inclusion Steering Group** The Terms of Reference and reporting structure for the ED&I Steering Group were presented and, of note, a new training package has been developed by Human Resources and the Patient Experience department, and was launched in November 2017. As of 31st March 2018, 4574 employees have completed the training package. **6. Health & Safety Steering Group (6 monthly) Report** Of note, there are a number of areas across the Trust where there are gaps/areas of concern with a major or moderate level of risk, due to non-compliance with regulations. The departments identified will be managed through Divisional processes in the first instance.	

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	Concerns were raised by the meeting regarding the content of the Health & Steering group report. Following discussion, it was agreed that MA would speak to Margaret Simcock and clarify. MA to also send the Health & Safety Steering Group (6 monthly) report. **Resolved: Report was accepted.**	**MA**
5.4	**Compliance Oversight Group minutes – April 2018** The meeting accepted the minutes from the April meeting.	
5.5	**Chairman's Report – CLIP Minutes – May 2018 – M Arthur** The meeting noted that future CLIP feedback would be going to Compliance Oversight Group. **<u>THEMED REVIEW</u>** A review of no harm / low level harm incidents reported between April 2017 and March 2018 did not highlight any theme of concern. However, two deaths and one serious harm incident were reported under the main category of patient security. The group were concerned about this and requested further information to be provided to the meeting, this was provided by the Governance Team, and it was concluded that these incidents had been recorded inappropriately and there were no major concerns related to the work of the Trust. Issue of incident categorisation was then discussed and the need to simplify – this matter to be brought to the attention of the Datix User Group. **<u>PALS SAFEGUARDING REPORT</u>** The report provided an update on complaints processed through the formal statutory complaint process which did not meet the Section 42 criteria to be considered as a Safeguarding investigation. This report represents data from April 2017 to March 2018. The Trust received 31 complaints which did not meet the Safeguarding criteria. This is approximately 8% of complaints received during this period. The main issues were: • 16 related to general care of the patient - pressure ulcers • Other themes included - communication, patient discharge, information, resources and clinical treatment. It was proposed a meeting with the safeguarding team is scheduled to review training / learning requirements particularly around improving communication with nursing homes and patient discharge. No cases have been referred to by the Ombudsman. **<u>LEGAL REPORT</u>** The paper covered the reporting period April 2017 to March 2018. During this period there has been a decrease in the number of clinical negligence claims received and an increase in the number of claims closed with no financial settlement. There was an increase in the number of claims closed with no financial settlement. Concern was raised by the increase in total damages and costs between 2016/2017 (£1,095,801) and 2017/2018 (£7,384,973). It was confirmed that this was due to historic high value claims being settled. There was a significant decrease in the number of personal injury claims received and an increase in the number of claims closed where a denial had previously been made and no action pursued, resulting in the limitation period to expire. There were 2 matters which were subject to adverse decisions by the H M Senior Coroner during the course of this financial year.	

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	NEVER EVENTS REPORT The group discussed this summary report covering all never events recorded in the last year. The single majority of causative omissions identified were human factors/human errors. The meeting discussed the report, particularly how human error issues can be addressed. **OTHER ISSUES DISCUSSED** A major haemorrhage Making It Better Alert to be issued following a serious incident. NHS Improvement PSRR Report recommendations to be circulated throughout the Trust via the Risky Business Newsletter **Resolved: Report was accepted.**	
5.6	**CLIP Minutes – May 2018** The meeting accepted the minutes from the May meeting.	
6	**Assurance Reporting / Themed Reviews** There are no themed reviews or assurance reporting for this month.	
7	**Issues of Significance for the Audit Committee** There were no issues of significance for the Audit Committee. **Issues of Significance for the Trust Board** **Advise** **New committee structure** Detailed minutes from QSIG and COG continue to give insight into the depth and detail of the discussions at these committees, in addition to the respective chairs' reports. In future CLIP will report to COG. **QGAC agreed an objective for 2018/19:** That the Trust will have developed during the year metrics which will enable the Board to be assured that it can adequately assess the performance of all the divisions, including in particular the new Community and Primary Division 3. Previous Community metrics have been removed from IQPR and the VI metrics, while welcomed, will need further refinement. QGAC will take an interest during the year in the ideas for metrics the new management team in Division 3 will be developing. **PALS Safeguarding report** This report to CLIP provided an update on complaints processed through the formal statutory complaint process which did not meet the Section 42 criteria to be considered as a Safeguarding investigation, and which no longer appears in the IQPR. This information will in	

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	future be included in the Patient Experience Report to the Board. The report presented data from April 2017 to March 2018. The Trust received 31 complaints which did not meet the Safeguarding criteria, approximately 8% of complaints received during this period. Of these, 16 related to general care of the patient - pressure ulcers. Other themes included communication, patient discharge, information, resources and clinical treatment. A meeting with the safeguarding team was proposed to review training / learning requirements particularly around improving communication with nursing homes and patient discharge. **Themed reviews** QGAC expects to receive a report on Emergency C-sections in July, and on Cancer waiting times in June. **Assurance** **Organ Donation Six Monthly Report to COG** For the financial year 2017/18, the Trust achieved 100% referral rate for potential organ donors (DBD/DCD) – a total of 9 patients. Seven of these patients proceeded to become actual organ donors, which is a significant improvement over previous recent years. The improvement is due to a change in leadership and team working and also a revised organ donation structure. **Hospital Transfusion Group Report to COG** Generally, performance relating to transfusion matters is very good across the organisation. Of note, there were 11 Serious Hazards Of Transfusion (SHOT) reportable incidents reported between 1st October 2017 – 31st March 2018, three of which were in obstetrics (low grade) including two anti-D treatments given to the wrong and/or inappropriate patients. Mandatory Training compliance for transfusion is currently at 90.4%. Notably, whilst all staff have access to the national e-learning package a more "user friendly" bespoke local e-learning training package has been developed, which may facilitate improved compliance figures. **QRV A5 Trauma and Orthopaedics** Generally positive report to QSIG on this, with all domains scoring good apart from safety which requires improvement, and response from A5 Wards Sister gave examples of improvements made or in hand since the visit. Detailed and pertinent discussion at QSIG. **Report: National Reporting and Learning System (NRLS): how to understand your patient safety incident reporting** This report from NRLS compared RWT's data from April 2016 to September 2016 with data from the same period in 2017. The board can take assurance from the fact that there is no evidence of potential under-reporting of incidents as a whole, there was no significant change in reporting levels per 1000 bed days, and reporting is now more timely. Governance will be looking at whether incidents classified as low and no harm are correct, whether the spread of reporting indicates any areas not that may not be reporting, and will monitor themes.	

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	Legal Report The paper to CLIP covered the reporting period April 2017 to March 2018. Compared with 2016/17 there has been a decrease in the number of clinical negligence claims received and an increase in the number of claims closed with no financial settlement. There was an increase in total damages and costs between 2016/2017 (£1,095,801) and 2017/2018 (£7,384,973), but this was due to historic high value claims being settled. There was a significant decrease in the number of personal injury claims received and an increase in the number of claims closed where the trust had denied liability and the claimant had not pursued any action, resulting in the period for making a claim expiring. There were 2 matters which were subject to adverse decisions by the H M Senior Coroner during this financial year. **Partial Assurance** **IQPR: Cancer waiting times** While other indicators showed improvement in April, cancer waiting times showed a drop, particularly 2 week breast symptomatic, down to 42.37%. This was partly due to local factors raising demand by 30%, but it also seems that nationally pressure is increasing. The Cancer Intensive Support team is visiting the trust w/c 4 June to look at pathways. Simon Evans gave a presentation to F&P on a cancer dashboard to track performance more closely, and will do so for QGAC in June. **SUI Report discussed at QSIG** Divisions to review outstanding SUI actions with a view to rationalising what needs to be done or to close; and to carry out theming of actions for commonality. Small group set up to discuss the detail, and feed back to QSIG. The issue of overdue actions from other items e.g. external reviews, Health and Safety etc were highlighted for the attention of both Divisions. **Quality Review Visit D7** QSIG received a report of a revisit in December 2017 following an earlier visit in February where there were 3 domains scored as requiring improvement. The revisit confirmed that improvements had been made, but 2 domains were still scored as requiring improvement. It also revealed multiple issues from different staff disciplines including documentation completion, use of stamps and the absence of standard ward rounds due to multiple specialty outliers on the ward. The issue of the knowledge, skills and training of D7 (Gynae) ward staff to manage multiple specialty patients was highlighted and consideration of training needs and support was to be given. **NatSips Audit reports to QSIG** Reports were received from Care of the Elderly (CoE) and Urology OPD. CoE reported positive assurance on safety and needed to take forward actions around the consent and patient information leaflets for elective Lumbar Puncture. Urology OPD reported positive results but audit sample size was small, therefore was asked to provide re-audit results in 6 month. **Trauma Governance Group - report to COG** Whilst there has been an improvement in compliance against the performance standards with respect to Trauma governance, two specific areas require a focus of attention, as follows:	

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	Patients with an ISS (injury severity score) greater than 15 to be seen by a Consultant within 5 minutes of arrival in ED. At present only 3.7% of such patients are assessed within this timeframe, compared with the Trauma Unit average of 14%. Improved triage and utilisation of a "Trauma documentation booklet" will improve compliance. Time to CT scan for head injury patients should be less than one hour. However, the Trust scores 33.3% compliance against the Trauma Unit average of 60%. The protocol for Trauma CT scans has now been agreed with the CD of Radiology and following this protocol, should enhance compliance. The Trauma Governance Lead will meet with the CD and Clinical Lead of the Emergency Services to discuss both of the above. **VTE Prevention & Treatment - report to COG** Compliance for VTE prevention and treatment assessments for patients admitted to the Trust is set at a minimum of 95%. Historically, the Trust reported compliance data for patients who received their VTE assessment at any stage following their admission. From April 2018 it has been agreed to report compliance against only those assessments made within 24 hours of admission. The Trust is to ensure assessments are undertaken across all admission portals/areas to maximum effect, including the use of the Maternity Badger system to enable electronic capture of ED assessments in Maternity. In addition, the VTE assessments have been extended to include 16-18 year olds. Previously, the cohort only included the patients 18 years of age or older. The impact of this new change is uncertain. **Never Events Report** CLIP discussed the summary report covering all never events recorded from January 2017 to March 2018. The majority of causative omissions identified were human factors/human errors and CLIP considered what other aspects, e.g. of the environment contributed to the human errors. **No assurance** **Health & Safety Steering Group (6 monthly) Report** COG was informed of a number of areas across the Trust where there are gaps/areas of concern with a major or moderate level of risk, due to non-compliance with regulations. The departments identified will be managed through Divisional processes in the first instance.	
8	**8.1 – Agreeing Objectives for the Committee for 2018 – 19 – R Edwards** RE asked the meeting for their thoughts about agreeing one or more objectives for this committee to focus on. She thought one had arisen in discussions: the need for suitable metrics for the new division 3 which would enable the board to see how well risks in VI and Community were being managed. The committee agreed and she offered to draft something for the QGAC chair's report. GN asked if Themed Reviews should be removed from the agenda, RE advised that in June the Cancer database would be reviewed, Maternity in July and Mortality and Safeguarding are also reviewed once a year.	

Item No		Action
	8.2 – Committee Self-Assessment of Effectiveness – R Edwards RE presented a QGAC Effectiveness checklist to the committee. After agreement it was agreed for CE to circulate and with the closing date of 4 weeks after this.	**CE**
8	**Evaluation of Meeting – ALL**	
9	**Any Other Business – ALL** MA advised the meeting that from July 2018 Keith Wilshere would be populating the BAF report and presenting to this meeting.	
10	**<u>Date and time of Next Meeting</u>:** Wednesday 20 June 2018, 2pm to 4pm, Room 1, WMI (was Syndicate Room)	

COMMITTEES ACTION SUMMARY REPORT

ITEM	Action to be taken raised from the meeting	Lead	Committee Date	Review date	Update
4.1 / 30.05.18	It was noted that at the early meeting of Finance & Performance, Simon Evans presented a new cancer dashboard that has been developed in house and will help to track the Trust performance. This was discussed at length and it was agreed to invite Simon Evans to the June QGAC to view this dashboard.	CE	30.05.18	20.06.18	
4.2 / 30.05.18	**4862 –** Neonatal cots – RE asked if the business case for additional staff had been approved at the April TMC, GN confirmed that it had and the department are out to recruitment. RE asked for the action regarding comment commencing *There are ongoing incidents relating to the lack of clinical equipment etc*, GN agreed to review this.	GN	30.05.18	20.06.18	
4.2 / 30.05.18	**3069** – Never Events within the Division – JS asked if this risk had been updated to reflect the meeting with the CCG in April. AMC to update.	AMC	30.05.18	20.06.18	
5.3 / 30.05.18	Concerns were raised by the meeting regarding the content of the Health & Steering group report. Following discussion, it was agreed that MA would speak to Margaret Simcock and clarify. MA to also send the Health & Safety Steering Group (6 monthly) report.	MA	30.05.18	20.06.18	 Enc 4.5 HSSG Report COG Apr 18.docx  Email from MA to QGAC members with

8.2 / 30.05.18	**Committee Self-Assessment of Effectiveness** RE presented a QGAC Effectiveness checklist to the committee. After agreement it was agreed for CE to circulate and with the closing date of 4 weeks after this.	CE	30.05.18	20.06.18	
5.2 / 25.04.18	**1713** – JS asked GN about the business case for recording electronic tool to assist with job planning. GN replied that an update paper went to the Executives, GN to add a revised date to this risk.	GN	25.04.18	~~30.05.18~~ 20.06.18	GN reported that she had had a conversation with Brian McKaig regarding conducting a complete review of the job planning risk. Brian McKaig will be reporting to the Audit Committee in August. Bring forward to the next meeting.
5.2 / 25.04.18	**4962** – RE queried *Evidence that it is working point 2, 102% occupancy in Q2 in Intensive Care (Feb 18),* RE feels that this does not show that it is working at 102% and after a brief discussion it was agreed to move to the column *Any evidence that it is not working*.	GN	25.04.18	~~30.05.18~~ 20.06.18	Bring forward to the next meeting.
5.2 / 25.04.18	**3069 –** JS asked if an update could be added to the *What else can we do?* column following the meeting for assurance. GN agreed to update.	GN	25.04.18	~~30.05.18~~ 20.06.18	Bring forward to the next meeting.
4.1 / 21.03.18	JS and RE expressed concerns about the rise in emergency C-Section rates, which had been increasing since November 2017 when it first went red and now stood at 20.6% compared with target of 14%. CE said that the rate tended to rise and fall over the year and usually ended up at around 20-24%. RE commented that this set of figures	CE	21.03.18	~~April or May meeting~~ ~~30.05.18~~ **25.07.18**	This action has not been picked up – DH agreed to sort and confirm if the report could be presented in May. Bring forward to May RE confirmed that a report will be presented in July due to data collection.

	was looking more like a trend and JS asked if a report could be presented at either the April or May QGAC meeting with the findings of the review conducted by the Directorate. CE to request the said report.				
9 / 21.02.18	MA mentioned that CE and RE were going to discuss at this meeting NED attendance at the PSIG and QSAG meetings, which are due to be renamed in March. Following a brief discussion, it was agreed to defer to the next meeting. CEm to add to the March agenda.	CEm CE CEm	21.02.18	~~21.03.18~~ 25.04.18 **25.07.18** 	CE informed the meeting that herself and RE had spoken. The terms of reference has is for Compliance Oversight Group and Quality & Intelligence Group. It was agreed that after 3 months the meetings would be evaluated to see the impact in terms of QGAC and to make sure that this meeting is assured that the attendees are not missing out on information that is filtering up. Bring forward – **Review of how the pilot committee structure is working.** CEm to speak to Keith Wilshire re sub groups being on Boardpad. – Completed – add documents to the Reading Room.

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
5.2 / 25.04.18	2080 - Risk to quality of patient care: reduced manpower (COO). Risk has been updated for April, several assurances have been added. The establishment issue in regards to trained and HCA staff is still noticeable. MA queried point number 9 and after a brief discussion it was agreed that AMC would review this risk.	AMC	25.04.18	30.05.18	AMC advised the meeting that staffing levels will be reviewed in January and June. AMC assured the meeting that no ward is vulnerable. The work around the establishment will be bi-annually and will change when services change. Reporting will be done more on patient care hours per day within the Board reports. Agreed to close this action.
5.2 / 25.04.18	4661 - Lack of robust system for review and communication of test results (MD). MA advised the meeting under section *Any Evidence that it is not working* November 2016 should be added to points 1-4 and 2 and May 2017 should be added to point 5. MA to update on datix.	MA	25.04.18	30.05.18	MA informed the meeting that the update to this risk missed the publication date of the report. The risk has now been updated and the dates added to datix. JO advised the meeting that there is a lot of active dialogue around the reviewing and reporting of results on the basis of some of the datix entries and the RCA's. Agreed to close this action.
5.2 / 25.04.18	**1714** – JS asked GN about this risk under column *Evidence that it is working*, if following the meeting with SSOTP in March if there were any actions to support the risk management. GN replied that there were a couple of actions which were discussed and left with SSOTP, mainly being the Trust does not have daily Social Worker input on site. SSOTP are going to ascertain how a daily Social Worker input on site. GN to update the risk.	GN	25.04.18	30.05.18	GN reported that this risk had now been deescalated from the risk register. Close

5.2 / 25.04.18	**4599** – RE informed MA that the date was missing on this risk. MA to amend.	MA	25.04.18	30.05.18	MA confirmed that the date of origin was August 2016 and the date of escalation was March 2017. These updates will be on the next report. Close
5.2 / 25.04.18	**4411** – RE queried *What else can we do?* – remove or relocate combustible storage in the Tugway. GN confirmed that this will be updated for next month's report.	GN	25.04.18	30.05.18	GN confirmed that this had been updated – close action.
4.2 / 21.03.18	**1714** – Discussions took place on this risk and it was agreed that this was no longer a Trust risk anymore and should be moved to Divisional risk register. CE mentioned that under the column ***what else can we do?*** the actions are out of date, GN confirmed that these actions have all been updated and asked PA to check if the update has been received.	PA	21.03.18	~~25.04.18~~ 30.05.18	JC replied to PA's email to advise that this risk will be discussed at Divisional Governance meeting on 11 April and the risk will be updated after this meeting. MA confirmed that both divisions had reviewed the risk and do not feel that there is anything else Divisionally which can be done and still feel it is a Trust level risk. GN confirmed that she had met with SSOTP which was a positive assurance update on the risk. GN to ask Tim Powell and Lewis Grant to update the risk. Agreed to bring forward to the next meeting. Duplicate action - close
4.2 / 21.03.18	**4706 –** RE asked if there had been any further outbreaks of insects since the last one reported in 2017. GN to remove the comment **1+*2. In 2017 there were 16 incidents reported on Datix of insects in theatres, two during operations with no known patient consequences (Sept 17).*** PA to asked Jo Colgan to update the risk.	GN / PA	21.03.18	~~25.04.18~~ 30.05.18	PA emailed Jo Colgan for clarification – 03.04.18. Jo Colgan to speak to Lewis Grant and update the risk accordingly. MA confirmed that as of September 2017 this risk was correct. Positive update has been added to datix regarding the number of insects. Agreed to bring forward. To be discussed under the risk register section of the agenda. Close