The Royal Wolverhampton
NHS Trust

Minutes of the Quality Governance Assurance Committee - 25 July 2018
1 October 2018

Minutes of the Quality Governance Assurance Committee

held on the:

Date **Wednesday 25 July 2018**

Venue **Seminar Room, Diabetes Centre**

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
	D Hickman **(DH)**	Deputy Chief Nursing Officer
	Dr J Odum **(JO)**	Medical Director
	G Nuttall **(GN)**	Chief Operating Officer
	J Small **(JS)**	Non-Executive Director
Attendees:	Dr T Vanner **(TV)**	Consultant – Obs & Gynae
Apologies:	D Loughton	Chief Executive
	J Vanes	Chairman

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:** It was noted that J Vanes was missing off the present list of the last minutes. **Page 5 –** risk 4734 – spelling correction – **reputational risk** and not a repetitional risk. **RESOLVED: Minutes of the Quality Governance Assurance Committee held on 20 June 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 – June – AM Cannaby & G Nuttall** GN presented the Performance section of the report and informed the meeting that an in-depth discussion had taken place at the Finance & Performance meeting earlier in the day. The meeting discussed the cancer targets and it was noted from GN that the cancer recovery plan will be June 2019; however this is still awaiting formal agreement from external bodies. The recovery is based on no increase in referrals; however there is a current increase across some of the cancer sites of referrals between 5 to 30%. GN will note more detail in future reports. JS asked why there was an increase and was informed that it was linked nationally due to cancer awareness campaigns and some is due to various pressures. GN confirmed that she has received the report from the Intensive Support Team and will share with everyone. Highlights from the report include standard operating procedures, training and education for some staff managing the cancer pathways. Support for these recommendations will come from the Intensive Support Team. Issues were also raised via the report on demand and capacity issues. The team will be starting within the Trust over the next couple of weeks and will be on site for 8 weeks, 5 days per week as part of the enhanced recovery programme. The team assured GN that issues raised within this Trust are a national pattern and not just within this Trust. AMC informed the meeting that she had just chaired a meeting in regards to the 104 days harm and it was an excellent meeting. CCG were present at the meeting and 5 patients were discussed where they had had their definitive treatment, no harm was identified from the patients. AMC advised that these meetings would take place on a monthly basis for as long as required.	**GN**

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	Asked about the scope to automate cancer tracking, which F&P chair said had been discussed that morning, GN explained that every trust has a cancer tracking team which works on the same principles as RWT's: they track every stage of the patient's journey from the day the referral is received and log it on the national cancer database. Currently the Trust has slightly less than 1500 patients that are being tracked by the team. It is an intensive job and not one she was aware had been automated at any NHS trust or anywhere else. Future reports will include Community Services Primary Care and Sexual Health metrics as there some national standards expected to be reported that the Trust will look to include, probably quarterly. AMC informed the meeting of the changes to the quality section of the report. The meeting noted the dashboards inserted into to the report allowing readers to review most of the indicators almost at a glance. AMC sought the Committee approval that this would be acceptable to see issues by exception. The meeting thought that the combination of graphical displays plus more detailed actions to issues identified would meet NEDs' and the committee's needs. AMC advised the meeting of the areas of concern to herself were: VTE Risk Assessments – a new system has been installed, portals are the issue in regards to the VTE assessments. The Trust is now giving the Divisions and Directorates monthly detail about the areas where there are problems. They will have the tactical detail both weekly and daily. There are issues in regards to manipulating some of the data. Focus will be more on the Junior Doctors at their induction and VTE's being made mandatory. AMC advised the meeting that some hospitals do not move patients without a VTE being completed. Following the Compliance Oversight Group, GN updated the meeting that she will be meeting with Dr Raghavan in regards to VTE assessments. The meeting discussed further with JO advising that the process changed in April and all assessments must be completed within 24 hours of admission. JO reported that this was not just a Wolverhampton issue but also within other Trusts. AMC advised that there is now a section in the report in regards to Mortality. The graph on the report indicates the SJR Divisional Allocation v Completed. The graph is from April 2017 to June 2018. JO advised that when the Medical Examiner commences in early Autumn SJR's will be reviewed by him/her meaning the Directorates will have less to review. JO advised that stage 2 SJR's are reviewed by Medics and non-Medics. RCA's in regards to deaths will now be asked if the death was avoidable which will be a yes or no answer. JO reported that an SJR can take a while to complete and the Medics do not have allocation within their job plan. RE asked how the Trust compares to other Trusts for outstanding SJR's. JO commented that he is amazed how so many Trusts have virtually no avoidable deaths and most Trusts are not reviewing as many deaths as they should do to achieve the percentage. JS commented that she was happy that it was in the report and makes it more transparent. The meeting discussed the new format of the report and following discussion approval was agreed. **Resolved: Report was accepted**	

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4.2	**Board Assurance Framework - K Wilshere** In the absence of KW, MA noted the following from the BAF report: 0 new risks 0 risks closed 3 red risks: • **SR1 –** Workforce – Recruitment & Retention of staff across the Trust and in particular the future pipeline of nursing and medical care • **SR8 –** That there is a failure to deliver recurrent CIPs • **SR9 –** That the underlying deficit that the Trust has in 2017 / 2018 is not eliminated in medium term to bring the Trust back to financial surplus. The meeting noted that the updates were made in red. GN assured the meeting that the report was discussed in-depth at Finance & Performance meeting earlier. MA advised the meeting that KW is looking to reformat the report. **Trust Risk Register Key Issues – M Arthur** MA presented the TRR paper to the meeting. The meeting was informed that **0 new risks.** **0 risks removed.** **5 red risks:** **2080** - Risk to quality of patient care: reduced manpower (COO) – update – action plan updated with 2 new actions. **4661** - Lack of robust system for review and communication of test results (MD) **4472** - Delays in Cubicle Assessment and Triage (COO) – some positive assurance added in regards to new metrics that have been developed. Additional actions added as well. **4113** - Division 1 failure to achieve CIP target (COO) – that has been updated and MA sought clarification. GN updated the meeting in regards to the £7m savings for the financial year. **4903** - Risk of non-compliance with Thoracic Service Specification (COO) MA advised the meeting that risk **5045** will be added to the update list however, this risk will be reviewed and re-written by next month.	

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	The meeting discussed the review date and agreed that if a risk has not been reviewed or updated the review date should stay the same. **2719** – RE asked for an update on this risk – GN advised that the business case is for 16 additional staff and will go through August's Contracting and Commissioning and will be a cost pressure. **4596 –** JS asked for an update on this risk in regards to the Directorate formulating a business case for a 4th Upper GI Surgeon. GN advised that this is still on-going and is does not know when the business case will be written. **4903** – JS asked for an update on this risk regarding awaiting decision of NHSE, the cost on thoracic work. GN replied that there is still no decision from NHSE and suggested that the risk is downgraded and be reviewed. **1713** – JS asked for an update on this risk asking where the risk currently stands. JO advised that the costings have been done. A revised business case will be discussed at the next TMC on Friday. **4718** – RE asked for an update on this risk regarding awaiting confirmation of approval of business case for Named Midwife post. AMC confirmed that interviews are taking place today. **4161** – RE asked for an update on the pending business case being developed for overseas nurse recruitment. AMC confirmed that there is a business case which has been developed and will go to Contract & Commissioning for approval. AMC advised that an additional paper is in the Trust Board pack for a Clinical Fellowship for Nursing. RE queried where the Trust would recruit overseas Nurses from, AMC advised the Phillippines. **4411** – RE asked for an update on the risk profile to be reviewed following installation of CCTV within the Tugway. GN advised that this will reduce the risk and go back to Divisional / Directorate risk. The work has commenced and will be completed by 18 August 2018. **Resolved: Report was accepted**	**GN**
5	**Sub Group Reports**	
5.1	**Chairman's Report – Quality & Safety Intelligence Group (QSIG) – June 2018 – A M Cannaby** **1.** Reporting changes have been agreed with the CCG for both falls and Pressure Injuries. Only those falls that identify omission in care and harm will be reported. This means that the accountability meetings will be held first to determine omission & harm from that omission and then reported to STEIS as appropriate. **2.** General ICCU LOCSIPPS – consent prior to CVC insertion not taken as current practice where able (i.e. where patient is conscious). **3.** C19 – QRV completed November 2017. Good with exception of the Safe domain. Re-visit requested for further assurance. **Resolved: Report was accepted.**	

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5.2	**Quality & Safety Intelligence Group minutes – June 2018** The meeting accepted the minutes from the June meeting.	
5.3	**Chairman's Report – Compliance Oversight Group (COG) – June 2018 – J Odum** **1. <u>End of Life (inc. SWAN) Steering Group Report</u>** The SWAN Steering Group is now renamed as 'End of Life' Steering Group. A draft strategy is to be produced for EOL Care in Q3. The national audit for care of End of Life will review 80 deaths with the submission date being October 2018. The EOL steering group is networking with other organisations RWT (including SaTH and Compton Care) to share best practice. There was a lengthy discussion regarding the use of GSF to identify EOL patients in the community and that different groups are reviewing processes and services that might help keep patients in their preferred place of death outside the hospital setting, improving experience for both the patient and family/carers. This is a priority pathway of care for the Wolverhampton Health Economy with a significant work plan. It was also acknowledged that the Trust should work to having an office for registration of deaths onsite. **2. <u>Radiation Safety Group Report</u>** Significant issues are changes in Radiation safety regulations from January 2018. These have been managed through RWT, but with some challenges. Implementation not yet fully embedded in certain areas. The Trust has additional ARSAC cover currently from an UHCW Consultant. ARSAC In house RWT Consultants are being trained to provide extra cover. There remains a backlog in reporting of MR and CT scans which is currently being managed both in house and with outsourcing. **3. <u>Sign Up to Safety Group Report</u>** At the time of the report 291 staff have been trained in PCM. The Trust has four PCM trainers. In the three targeted areas the highest uptake is in Maternity followed by Trauma and Orthopaedics. Release of staff from the Emergency Department has been hindered due to clinical time commitments. Feedback from those trained is positive and of high quality. NHSLA is satisfied with the progress being made. The Trust is in year 2 of the programme (set for 3 – 5 years) with a 'non-recurrent' budget. There may need to be discussions regarding continuation of delivering the programme and required funding, with review of outputs from the programme.	

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	4. Patient Experience Group Report Complaints in O&G have risen (12) in Q4 2017/18 with themes of clinical care and general care of the patient predominating. Triangulation with FFT and the increase in the birth rate cap and other work is to be undertaken through a deep dive. **5. Clinical & Theatre Products Evaluation Group Report** Good progress is being made with the new process to manage changes to alternative clinical products. This involves using clinical experts from RWT being involved in the decision as to which products to review and replace. The clinical and theatre products evaluation group (C/TPEG) manage the process and communication of change is determinated widely across the organisation. Good progress is being made in this area. **Resolved: Report was accepted.**	
5.4	**Compliance Oversight Group minutes – June 2018** The meeting accepted the minutes from the June meeting.	
6	**Assurance Reporting / Themed Reviews** **6.1 – Litigation & Inquest 2017/2018 report – M Arthur** MA presented the above report. The Committee noted that this report had previously been presented at the June Trust Board and agreed that the overall review of the report was showing a good picture. MA reminded the meeting that with the reduction in claims this will equate to a decrease in premium. **6.2 – Emergency C-Section – Dr T Vanner** TV presented the above paper to the meeting. This paper was requested by QGAC because the emergency caesarean section rate had been red (>16%) on the monthly Maternity dashboard since November 2017. TV advised the meeting that Maternity is now using an electronic system called BadgerNet which holds the patient records and this system was used by TV to collate the report. TV assured the meeting that future reports will contain more detail. The report indicated that during 2017.18 the emergency caesarean section rate is 15.99% which is amber. However, during this period the elective caesarean section rate has been green for most of this time. The combined caesarean section rate for the financial year of 2017/18 is 27.85% which is amber. TV mentioned that a national report received in November 2017 from the National Maternity and Perinatal Audit for the period of April 2015 to March 2016 indicated the national caesarean section rate was 25.9%. During the same period the Trust was 28.7%. The meeting was informed that many of the elective caesareans become emergency and then are counted as emergency sections. TV feels that is why the Trust's elective section rates are always green and the Trust emergency section rates are always red. TV advised the meeting	

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	that in June 7.4% of emergencies were originally booked as elective. The meeting discussed the report. DH mentioned the high rate of inductions, and that this figure is also in the red, and that inductions often lead to emergency CS. TV mentioned that a number of staff are locus, though most are long term and one has been taken on as a Trust Grade Doctor. It may be that less experienced doctors have a lower threshold for CS. The unit is busier, there are more locus, the induction rate is up and instrument deliveries are relatively low. TV explained to the meeting why women ask for a caesarean section (for example the fear of a vaginal birth) There are at present no written guidelines for induction in relation to reduced feral movement. An AFFIRM study is looking at the issue of reduced fetal movement and when it reports it may lead to useful guidelines. RE mentioned that the reason for asking for the report was to seek to understand the underlying causes of the rising emergency C-section rate and find out what can be done to support the department. TV assured the meeting that now BadgerNet was in place it would be easier to monitor as the data quality will be better. The Committee would like a further report but did not specify a date. **[action: committee to consider at next meeting]**	
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** **<u>Issue: evaluation of new COG/QSIG meeting structure</u>** A meeting was held with the chairs of the new COG (Jonathan Odum) and QSIG meetings (Ann-Marie Cannaby) to evaluate the operation of the group functions to date. The outcomes discussed were: 1. The new meeting format allows for better focus on quality and safety performance detail with Divisions. 2. Information transfer from COG to QSIG (where appropriate) has been helpful 3. Divisional highlight report population is progressing to ensure actions update across all reported items 4. Use of all elements of the data pack is evolving eg. Divisions reminded to include Mortality content in highlight reports 5. Dashboard and data pack provision is timely and dashboards now report on the preceding completed month's data NEDs at QGAC confirmed they feel they are receiving adequate information/levels of assurance via the chairs' reports as opposed to former attendance at the previous group (QSAG, PSIG) meetings.	

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	It was agreed to: 1. Add prompts to Divisional highlight report template to ensure all content is covered 2. Consideration needed on the Trust level of risk review (whether at QSIG or a separate meeting) 3. Ask divisions for their views. **<u>Issue: format of Integrated Quality and Performance Report</u>**: QGAC agreed with the proposal to provide a dashboard summary of key issues and reporting by exception, providing more text on what the issues are and what actions are planned. QGAC also wished to have means to retain an overview of things that are going well, to give a sense of balance and allow sharing of good practice. The changes to the format will be an iterative process. **<u>Issue: End of Life (inc. SWAN) Steering Group Report to COG</u>** The SWAN Steering Group is now renamed as 'End of Life' Steering Group. A draft strategy is to be produced for EOL Care in Q3. The national audit for care of End of Life will review 80 deaths with the submission date being October 2018. The EOL steering group is networking with other organisations RWT (including SaTH and Compton Care) to share best practice. There was a lengthy discussion regarding the use of Gold Standards Framework to identify EOL patients in the community and that different groups are reviewing processes and services that might help keep patients in their preferred place of death outside the hospital setting, improving experience for both the patient and family/carers. This is a priority pathway of care for the Wolverhampton Health Economy with a significant work plan. It was also acknowledged that the Trust should work to having an office for registration of deaths onsite **Assurance** **<u>Issue: Sign Up to Safety Group Report to COG</u>** At the time of the report 291 staff have been trained in PCM. The Trust has four PCM trainers. In the three targeted areas the highest uptake is in Maternity followed by Trauma and Orthopaedics. Release of staff from the Emergency Department has been hindered due to clinical time commitments. Feedback from those trained is positive and of high quality. NHSLA is satisfied with the progress being made. The Trust is in year 2 of the programme (set for 3 – 5 years) with a 'non-recurrent' budget. There may need to be discussions regarding continuation of delivering the programme and required funding, with review of outputs from the programme. **<u>Issue: Clinical & Theatre Products Evaluation Group Report to COG</u>** Good progress is being made with the new process to manage changes to alternative clinical products. This involves using clinical experts from RWT being involved in the decision as to which products to review and replace. The clinical and theatre products evaluation group (C/TPEG) manage the process and communication of change is disseminated widely across the organisation.	

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	Issue: reporting on falls and pressure injuries: reporting changes have been agreed with the CCG. Only those falls where omission in care resulted in harm will be reported. This means that the accountability meetings will be held first to determine omission and harm and then reported to STEIS as appropriate. Only avoidable PIs will be reported on STEIS. This stems from work by Governance to make sure the Trust doesn't report everything, but focuses on what the guidance requires to be reported. **Partial assurance** **Issue: Radiation Safety Group Report to COG** Significant issues are changes in Radiation safety regulations from January 2018. These have been managed through RWT, but with some challenges. Implementation not yet fully embedded in certain areas. The Trust has additional cover to comply with ARSAC (Administration of Radioactive Substances Advisory Committee) currently from an UHCW Consultant. ARSAC In house RWT Consultants are being trained to provide extra cover. There remains a backlog in reporting of MR and CT scans which is currently being managed both in house and with outsourcing. **Issue: Emergency Caesarian Section rate:** QGAC received a report on this, in view of this rate being red (>16%) since November 2017. This high rate is associated with a high induction rate. The Trust at present has no written guidelines on induction related to reduced fetal movement and the outcome of an AFFIRM study on this may help in determining good practice. **Issue: Integrated Quality and Performance Report: VTE:** reporting rates have declined since the new system was instituted. Various ways to improve compliance are being explored. VTE assessment before patients leave their point of entry to the trust is one way forward. There is also a focus on junior doctor induction, and increased information to divisions. **Issue: reporting mortality and avoidable deaths:** QGAC considered the dashboard report in the IQPR on mortality, and agreed that it provided the information needed to assess the extent of the reviews being done in the trust and the outcomes. QGAC noted that there was a backlog, which would require resource to clear, and that it was expected that appointing to a Medical Examiner role would provide more focussed and better targeted reviews. **Issues for Audit Committee** There were none No assurance	
8	**Evaluation of Meeting – ALL**	
9	**Any Other Business – ALL** **9.1 – Review of how the pilot committee structure is working – M Arthur** MA updated the Committee on a meeting which had taken place between herself, AMC and JO to evaluate how the new meeting structures have been going. The new format helps the	

Item No		Action
	groups to focus on quality and safety in detail with the Divisions. There has been a helpful information transfer between COG and QSIG. The highlight report is an evolving report and the dashboard data is the previous month. There is still room for development within the reports. The meeting discussed the feedback and it was suggested that a questionnaire is sent to the Divisions for their opinion and views. This was agreed.	**MA**
10	**Date and time of Next Meeting:** Wednesday 19 September 2018, 2pm to 4pm, Room 6, WMI **Please note the change of venue**	

COMMITTEES ACTION SUMMARY REPORT

ITEM	Action to be taken raised from the meeting	Lead	Committee Date	Review date	Update
4.1 / 25.07.18	GN confirmed that she has received the report from the Intensive Support Team and will share with everyone.	GN	25.07.18	19.09.18	
4.2 / 25.07.18	**4903** – JS asked for an update on this risk regarding awaiting decision of NHSE, the cost on thoracic work. GN replied that there is still no decision from NHSE and suggested that the risk is downgraded and be reviewed.	GN	25.07.18	19.09.18	
9.1 / 25.07.18	**Review of how the pilot committee structure is working – M Arthur** MA updated the Committee on a meeting which had taken place between herself, AMC and JO to evaluate how the new meeting structures have been going. The new format helps the groups to focus on quality and safety in detail with the Divisions. There has been an helpful information transfer between COG and QSIG. The highlight report is an evolving report and the dashboard data is the previous month. There is still room for development within the reports. The meeting discussed the feedback and it was suggested that a questionnaire is sent to the Divisions trios for their opinion and views. This was agreed.	MA	25.07.18	19.09.18	

4.2 / 20.06.18	**4661** - Lack of robust system for review and communication of test results (MD) – this risk needs to be updated with results if available.	JO	20.06.18	~~25.07.18~~ 19.09.18	MA confirmed that this risk had not been updated. JO informed the meeting that the Directorates are now using the I system for filing of the pathology reports (for Outpatients only). After a brief update and assurance from JO that he would obtain feedback it was agreed to bring this action forward to September.
4.2 / 20.06.18	MA mentioned risk **4734** – Mortality risk (MD) – there is no positive or negative assurance but there is on-going work into the investigations of alerts that have been received. Risk to be populated. DH advised that JO is developing an action plan which will help to populate the risk. Following discussion it was agreed to review this risk and reviewed due to the risk of the reputation to the Trust.	JO	20.06.18	~~25.07.18~~ 19.09.18	MA mentioned about the development of the dashboard on mortality, however, the risk has not been updated. JO confirmed that this risk would stay on the TRR as well as appearing on the BAF as a reputational risk. The meeting suggested that the risk could go on the BAF and the detailed separate actions be monitored there - the workforce risk was a useful example. It would then be monitored at QGAC. JO to ask Jane McKiernan to update the risk – bring forward to September.
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~~	GN reported that 4862 is going to be amalgamated with risk 4962. GN said that when she asked about "ongoing incidents relating to the lack of clinical equipment etc" no-one knew of any. RE asked that, in order to close this out, the originators of the risk be formally asked for the reasons behind this previous negative assurance, whether there had been any incidents, and what action had been taken. Bring forward to July meeting.

				~~25.07.18~~ 19.09.18	GN confirmed that she did chase for an update on this risk however did not receive a reply and therefore this risk was not updated – bring forward to September.
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~~ ~~25.07.18~~ 19.09.18	CE confirmed that the closing date is the 11 July – bring forward to the July meeting. CE confirmed that she is waiting for a couple of more responses and will bring to the September meeting.
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 ~~25.07.18~~ 19.09.18	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. GN confirmed that she had spoken to Brian McKaig who agreed to update the risk; however, this will now be done in readiness for the Audit Committee in August. Bring forward to the next meeting. GN confirmed that this risk is not yet been updated but is being prepared for Audit Committee – bring forward to September 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
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 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.	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. On agenda - completed
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. – on agenda - completed** CEm to speak to Keith Wilshire re sub groups being on Boardpad. – Completed – add documents to the Reading Room.