North Cumbria University Hospitals NHS
NHS Trust

MINUTES OF THE GOVERNANCE & QUALITY COMMITTEE HELD ON 28 FEBRUARY 2012 AT 1:30 PM VIA VC USING BOARDROOM, CIC AND BOARDROOM WCH

Present:
Michael Bonner, Non Executive Director (MB)
Damian Gallagher, Director of Human Resources (DM)
Ramona Duguid, Director of Governance & Company Secretary (RD)
Corinne Siddall, Director of Operations (CS)
Clive Graham, AMD Support Services (CG)
Mike Walker, Medical Director (MAW)
Vicki Bruce, Non Executive Director (VB)
Judith Cooke, Non Executive Director (JC)
Alistair Mulvey, Director of Finance (AMU)
Alan Davidson, Director of Estates (AD)
Helen Kelly, Head of Patient Safety & Clinical Governance (HK)
Anne Musgrave, Head of Midwifery (AM)
Jessica Riddle, Patient Panel (JR)
Barbara Hoyle Head of Education & Academic Development (BH)
Jan Forlow, Pharmacy (JF)
Kathy Barnes, Head of Medical Governance & Clinical Standards (KB)

In Attendance:
Gillian Hetherington, PA
Paul Wiggins, Deputy Director of IM&T (PW)
Lesley Carruthers, Deputy Director of Nursing (LC)

GC 8/12 **WELCOME AND APOLOGIES FOR ABSENCE**

MB welcomed all to the meeting and it was noted that the meeting was deemed to be quorate.

Apologies for absence were received from Chris Platton, Margaret Bailey, Carole Jordan

GC 9/12 **MINUTES OF THE LAST MEETING**

The minutes were accepted as a true record.

GC10/12 **MATTERS ARISING AND ACTION PLAN**

(a) JR asked for clarification of page 5 of the minutes re "A & E sisters meetings have also been reviewed to ensure they are looking at the key governance issues in accordance with the Trust's core pillars of governance". RD

explained that there are six core pillars of governance which form the Governance Strategy. She **AGREED** to send JR a copy of the core pillars of governance with an explanation of what they are.

(b) **Action: GC 6/12** – with the regards to the NPSA alert, Jan Forlow (JF) explained that this is an ongoing issue. They are trying to get clinicians to engage and discussions have taken place at Safe Medicines Practice Group (SMPG). She confirmed that this will be set up on the Pharmacy Intranet site for easy access by clinicians. MAW confirmed that these issues need to be brought to the Clinical Standards Sub Group (CSSG) to get on the Clinical Director agenda. The Governance Facilitators/Business Managers will need to be used to drive this sort of thing through the divisions. RD stressed that a timescale was required to ensure clarity as to when these alerts would move to green.

(C) JR commented that Governance & Quality papers include a lot of acronyms and she asked if it would be possible for these to be in full on at the least front sheet, so that lay people know exactly what these mean.

Actions:

1 RD to send JR a copy of the core pillars of governance with an explanation.
2 JF to arrange for discussion at the CSSG with regard to the NPSA alert on preventing fatalities from medication loading doses and timescale to ensure Trust compliance with this.

GC11/12 COMPLIANCE & REGULATION

(a) Policy Resume

HK presented the Policy Resume, to inform the Committee of the guidelines, the policies, the protocols and procedures which had been ratified by the Trust Policy Group since last reporting in January 2012.

- Equal Opportunities Policy (HR) – Review
- Patients Group Directions Policy (HR) – Review
- Illegal Possession of Illicit Substances Policy – Review
- External Agency Visits and Accreditations Policy & Procedure – Review
- Development & Management of Trust Policies & Procedures – Review

- Tracking and Retrieving Health Records Procedure – Review
- SOP – Controlled Drugs on Wards/Departments – New
- SOP – Prescribing of Controlled Drugs - Review
- SOP – Prescribing & Administration of IV Drugs – Review

Maternity Guidelines:

- Arranging the Antenatal Booking – Review
- Antenatal Risk Assessment – Review

- Caesarean Section – Review
- Care of Women in Labour – Review
- Eclampsia & Severe Pre-Eclampsia – Review
- Immediate Care of the Newborn – Review
- Induction of Labour – Review
- Labour – Clinical Risk Assessment – Review
- Severely Ill woman – Review
- Shoulder Dystocia – Review
- Support for Parents – Review
- Vaginal Birth after Caesarean – Review
- Venous Thrombo Embolism – Review

MAW asked for reassurance that the Maternity policies/guidelines are in place on both sites and that there is evidence that they are being implemented and audited. AM confirmed that in practice these guidelines are in place on both sites; although it is for CNST 2 that they are required to be in practice. She confirmed that 10 sets of cases notes are reviewed every month to check guidelines.

As regards to the action from the last meeting, HK confirmed that the front sheet of this paper had been changed to read: "Members of Governance & Quality Committee are asked to note the documents approved at the Trust Policy Group since last reporting."

JC raised a query with regards to type of policy, as it is not clear in this paper for all policies/guidelines. HK confirmed that this is an error and assured JC it will be rectified for the next meeting.

The Governance & Quality Committee **NOTED** the documents which had been approved by the Trust Policy Group.

(b) <u>NHSLA</u>

HK gave a verbal update on the NHSLA assessment which took place on 15 February 2012. She confirmed that we were assessed on 50 standards that describe our handling of risk in the organisation. We passed 49 out of 50 which is the best result the Trust has ever achieved and the assessor's feedback was very positive. She informed the Committee that we had failed on the Medical Devices Training Policy. AD confirmed that this had been discussed in Audit Committee that morning and there is still 2 months' work to bring this together and then 12 months of evidence is required to go forward with it.

The assessor offered to facilitate sessions within the Trust to support our moving to the next level. A clear action plan is now being developed to move the Trust to level 2.

HK informed the Committee that Standard 4 assessment is around clinical care and the assessor was very complimentary of the policies set out in this Standard and commented upon the clarity of the documentation.

With regards to Medical Devices training, MB asked for clarification around

whether we have staff at certain levels who have not been trained or is it that we have not got a record of whether they have been trained. LC explained that they have evidence in various ways but not one document that states that a member of staff has particular competencies signed off. She explained that this is one of the issues which will be taken forward by the Quality Matrons once they are in post. MB asked for assurance that people who should be trained are trained. LC assured him that this was the case. RD felt that an air of caution needed to be shown around this particular issue, because if we do not have the evidence to show that training has been completed across the Trust, therefore we cannot be assured until we have that piece of evidence in place. VB agreed with this. RD highlighted the action plan in place to ensure we maintain compliance with the CQC regulation.

The Governance & Quality Committee thanked HK for the information and MB asked if the Team could be thanked for all their hard work, enthusiasm and commitment to this.

(c) CNST (Clinical Negligence Scheme for Trusts)

AM informed the Governance & Quality Committee that they had had their CNST assessment on Wednesday, 22 February 2012. She explained that we achieved 10:10 on Standards 2-5, which is around Clinical Care; Standard 1 we achieved 8:10, this is the Governance section. With regards to the Governance Section the assessors commended the changes to the Risk Management Strategy but areas where we were weak were the annual staffing audits for midwives, which require some minor tweaking.

The feedback from CNST was extremely positive and supportive and in practice Governance and risk is robust. Once the report comes through there will be a robust action plan put in place.

The Governance & Quality Committee thanked AM for reporting on the assessment and MB asked if the Team could be thanked for all their hard work, enthusiasm and commitment to this.

GC12/12 WORKFORCE GOVERNANCE

(a) New Core Mandatory Training Requirements

BH presented this report to Governance & Quality Committee to update them on the changes to mandatory and statutory training in the Trust. She explained that this year this report is different as changes have been made to the 2012 mandatory training to reflect the 10 core subjects delivered by the majority of organisations across the Health section in the North West. This core framework is known as the Core Mandatory Skills Programme.

VB expressed confusion of this paper in terms of the records which are attached; they show very low proportion of people doing the training. VB commented that the training report was confusing and did not clearly highlight the key issues. BH explained that in the new programme which is coming in, this information will be much clearer and the Trusts training reports will reflect the new Core and Trust

mandatory training.

JC felt that what is required is the following:

- Core Mandatory Skills;
- Trust Mandatory training
- How often training needs to be done;
- What proportion of people in the Trust have completed within the time period;

but in a much simpler summary.

DG explained that the Trust is moving towards a target which is used nationally, and we have our Information Department working on this at the moment. The gold standard is to move to ESR.

RD informed the Committee that one of the difficulties for the Trust has been around the amount of time staff have to be released for training. The updated study leave policy states that all staff will be allocated up to 2 days to undertake their mandatory training and this will be confirmed to staff by 2 March 2012.

AMU felt that from a Governance Committee perspective, the information is a lot simpler than previously. He felt that if we are not where we need to be with regards to mandatory training then are we doing the right things to resolve the problems.

VB said that there are lots of other things we do where we have a lot of very detailed reports which are rag rated. She felt sympathy for staff who do not want to do training over and over again but there are things that we need to be assured of.

CS felt that as a Governance Committee we should not be managing performance, we should be looking for assurance that these things are in place. VB felt that the Governance Committee is asking for data that allows us to be assured but that we can also understand.

It was agreed that the next report on mandatory training (May 2012) will be presented in a more user friendly way highlighting the key issues.

The Governance & Quality Committee **NOTED** the report and MB thanked BH for presenting it.

Action: New Core Mandatory Training Requirements – It was agreed that the next report on mandatory training (May 2012) will be presented in a more user friendly way highlighting the key issues.

GC13/12 STANDARDS, SAFETY & EXPERIENCE

(a) Infection Prevention Report

CG presented this report to Governance & Quality Committee, to provide a summary from the Infection Prevention Team for the period January-February 2012.

MRSA – There have been no apportioned cases for over 20 months.

MSSA – There was one Community acquired case in January 2012.

CDiff – There were 4 cases in January, we remain in trajectory for this financial year. CG felt that with regards to CDiff the Governance & Quality Committee should be asking for assurance around target set for next year, which is 40 Trust apportioned cases. So far this year we have had 49.

AMU queried CDiff on Willow B as this area has had the most cases throughout the year. CG explained that there have been structural issues around Willow B identified but could not confirm if these had been resolved. This is the Renal ward where there are a lot of very sick patients. CG **AGREED** to check and report in more detail on this in the next report and RD also suggested it would be useful to bring back outcomes from the RCA (Root Cause Analyses), for this and other cases.

AD confirmed that there is a meeting arranged for 7 March with CG and CP to discuss what action to be taken to meet increased target for next year.

RD confirmed that with regards to 3.1.5 Incident; this has been discussed in some detail through the weekly Governance meeting. Risk from this is very minimal, and an exception report will be included in the next Infection Prevention report.

MAW queried with regards to 9.1; if the Surveillance System is important. CG confirmed that it has always been felt it would be something very helpful to the IP team.

AMU questioned the Hand Hygiene and Saving Lives figures for January, which appeared to have dropped. CG explained that this is something which only happened in January and on checking February figures the percentages are back up.

The Governance & Quality Committee **NOTED** the report and MB thanked CG for the presenting it.

Action: Infection Prevention Report –

1 With regards to CDiff numbers, CG to report in more detail on the next report, along with outcomes from RCAs.
2 RD to include an exception report on Incident in the next IP report.

(b) Medical Records Update

AMU presented this report to the Committee to update them on the three questions relating to medical records:

- Staff resources
- Issues with medical secretaries
- Long term strategy

VB suggested that this could be an example of something we could speak to Northumbria about. AMU felt that his concern with this would be that Medical Records are not at the moment in the state they need to be in; there are problems with Clinicians accessing notes etc. There needs to be a solution that gives us assurance that records, as they are today, are fit for purpose. AD confirmed that if you go with the Northumbria system tomorrow you still have got an 8 year cycle for the medical records in the organisation. He also confirmed that we have a redevelopment at WCH starting in July and there is no facility for medical records in there.

MB on behalf of the Committee, thanked AMU for the update.

(c) Medical Devices Update

AD presented the Medical Devices Update to the Committee to update them on action taken to improve the governance arrangements regarding the management of Medical Equipment following the last report on 22 November 2011.

He went through this report and informed the Committee that a full presentation had been given at the Audit Committee earlier in the day. He said that a number of actions had been agreed at the Audit Committee and he would bring these back in the form of a Matrix to the March Governance Committee. He also explained that a more detailed paper was being prepared for the CSSG meeting on 2 March 2012.

AD explained that a lot of work had been done in the last 3 months but there is still a lot of work to do to fill some of the assurance gaps but this will be more detailed in the report which will come to the March meeting.

The Committee **NOTED** this report and MB thanked AD for presenting it. It was also noted that the Chairman of the Audit Committee would be attending the March 2012 Committee for the Medical Devices Update.

Action: Medical Devices Update - AD to bring a more detailed report to the March 2012 Governance & Quality Committee.

(d) **Intensive Support Team (IST)**

CS informed the Committee that the IST had come into the Trust at our request to help us with some assurance around Emergency Care. They visited on 24

January 2012 for one day. They had one team at CIC and one team at WCH, so there are 2 separate reports. The reports have been considered at Executive team; both these reports are very frank and honest on where we are with our services. CS explained that this was a visit around quality and efficiency/best practice and had been initiated operationally following the concerns which had been raised in the A & E department about quality of care. The IST were very clear that if they encountered any of these concerns around quality of care they would raise it with us. They assured us there were no concerns raised around the quality of care being delivered and services and processes they were seeing.

After discussion with the Executives, two workshops/feedback sessions were held with Clinicians on each site.

CS informed the Committee that they are reviewing recommendations and are in the process, with the Division, of updating the Emergency Care action plan and Elective Care action plan to ensure recommendations from the IST visit are incorporated. She explained that it is important that we do not just circulate the report and recommendations but that we are actually aware of what the issues are and we are dealing with them via the action plans. She confirmed that Clinicians have now seen the report and have accepted the report as a fair representation of where we are.

In conclusion, CS informed the Committee that it was a successful visit in the main. There are a few things that we have not already picked up and we will be taking these forward; these are processes which are nationally being adopted in Centres of Excellence.

MB queried where monitoring of the action plans sits. CS confirmed that our internal work is being monitored by the System Wide Board, which is a Chief Executive's Board. The two plans are actually held by the Turnaround Programme in the PMO (Project Management Office) and will be monitored internally by the CRB (Corporate Recovery Board).

RD suggested to the Committee that the IST report and associated action plans are of a level of significance that it should be report to the Trust Board. AMU agreed that it should go to Trust Board, as there are lots of different parts to the report, for assurance on these important pieces of work.

Patient safety is paramount in this. JR would like the Patient Panel to be assured of patient safety. CS confirmed that she would be happy to come along to one of the Patient Panel meetings to talk through this.

The Governance & Quality Committee thanked CS for the explanations and assurances she gave and noted that a further report would be given to the Trust Board.

Action: IST Visit – CS to attend a Patient Panel meeting to talk through patient safety with the Patient Panel members.

(e) **Patient Waiting List Status**

CS brought the Patient Waiting List Status report to Governance & Quality Committee to inform them of the current status of Patient Waiting Lists and waiting time for Diagnostics. She explained that these are managed/monitored on a weekly basis in a meeting chaired by the Divisional General Manager for Medicine/Surgery. We also report on a weekly basis to the SHA our 18 week position and also on incomplete pathways because they are watching our 18 week performance due to Ophthalmology.

VB found this a very clear report, getting the balance right is actually quite difficult in terms of managing it. CS confirmed that it is managed very carefully with clinicians involved in all decisions.

JC confirmed that this is a very clear document. Over 26 weeks, some will be there by choice, some through bureaucratic problems; how do we keep communication up with them. CS explained that there is a patient choice list on the PTL (Patient Treatment List) and this still has to be reported at the weekly meetings; so patients are by exception picked up at the meetings and the Business Managers do also communicate on a regular basis with patients. CS also went on to say that there is regular validation of waiting lists and before extra capacity is put into the system they always check the waiting list to say "do you still want your operation", this is a priority.

MB found this very useful, even though all of the data is reported in the Performance Dashboard to Trust Board, the Governance Committee just wanted to look at something separate. AMU not sure why from a Governance Committee perspective this report needs to come to the Committee.

VB felt that the report had answered questions which had been asked.

The Governance & Quality Committee **NOTED** the report and MB thanked CS for presenting it.

(f) **Investigation and Resolution of Complaints**

HK brought this report to the Governance & Quality Committee to inform members of the improvements that have been made in the handling of complaints during the last year. Due to time limitations the paper was taken as read and HK asked for any questions.

VB felt that timeframes should be identified for certain targets. HK stated that legislation states that realistic timeframes should be agreed with complainants, and the possible complexities of the investigation made known. She explained that they generally work to 25 working days but cannot give 100% assurance that complaints will be completed within 25 working days. AMU queried whether there are more or less complaints answered within the 25 days than we used to and RD stated that yes we were performing better than before the introduction of the revised system. MB asked if there is a trend and do we respond to people's complaints in a timelier manner. HK was then asked to return with evidence of our improved performance.

The Governance & Quality Committee **NOTED** the report and MB thanked HK for presenting it.

Action: Complaints – HK to bring evidence of improved performance back to the April 2012 Governance & Quality Committee.

GC14/12 RISK MANAGEMENT

Never Events Framework

This report was deferred to another meeting because of time. It was, however, **AGREED** that the policy on Never Events could be updated.

GC15/12 INFORMATION GOVERNANCE

Information Governance Toolkit Self-Assessment 2011/12

PW attended the Governance & Quality Committee to present the IG Toolkit Self-Assessment 2011/12 to advise members of progress in respect of the 2011/12 V.9 Toolkit self-assessment. He explained that the target for IG is far higher than anything else at 95%.

As discussed in November meeting we were at 63% compliant, now we are in the low 70% with the standard being 95%. Last year we got an extension to June but PW confirmed this is not going to happen this year and he doesn't see how we will get to 95%. There are also other issues around Corporate Records Management; we have procedures in place and we apply those procedures.

JC felt that this is clearly a very aspirational target, but it is about pushing on. MB thanked PW for his very honest presentation but we as a Governance Committee need to know what the consequences are. AMU said that he is reasonably confident that we will not achieve 95%, however, we do need to push on. Information is being sent out, we are doing everything we can. There have been a number of IG incidents and people need to be aware of their responsibilities. In terms of Corporate Records Management, AMU will catch up with PW to see that we are doing everything we possibly can.

The Governance & Quality Committee **RECEIVED** the report and MB thank PW for presenting it.

Action: Corporate Records Management – AMU to meet with PW to ensure we are doing everything we possibly can to meet targets.

GC16/12 STANDING ITEMS

Minutes/Action Plans of Meetings

(a) Emergency Preparedness SG – 5 December 2011 - The Committee **NOTED** the minutes.

(b) Safeguarding Board held 11 November 2011 - The Committee **NOTED** the minutes.

(c) Safeguarding Board held 13 January 2012 – The Committee **NOTED** the minutes.

(d) Terms of Reference – Safeguarding Board – deferred to next meeting.

(e) Trust Infection Prevention & Control Committee held 29 November 2011 - The Committee **NOTED** the minutes.

(f) UNRATIFIED Health & Safety Committee held 18 January 2012 – RD asked if AD could make sure the Action Plan is updated, this has still not been done.

(g) ToR Health & Safety Committee – deferred to next meeting.

Action: Health & Safety Committee Minutes - AD to arrange for the action plan to be updated before the next Governance & Quality Committee.

GC17/12 ANY OTHER BUSINESS

(a) Governance Improvement Plan

RD confirmed that there are a number of areas which will not be "green".

(b) Governance & Quality Terms of Reference

The terms of reference would be discussed at the March 2012 meeting.

GC18/12 DATE & TIME OF NEXT MEETING

The next meeting will take place on **Tuesday, 27 March at 1.30 pm via vc using the Boardroom, WCH and Boardroom CIC with the Boardroom WCH being the main venue for the meeting**

GOVERNANCE & QUALITY COMMITTEE ACTION LIST – FEBRUARY 2012

DATE OF MEETING: 27 March 2012

Minute Point Reference	Details of Action Agreed	Action by whom	Target Date	Progress
MAY 2011				
GC35/10(a)	**Medical Records –** Mr A Mulvey to ask Mr M Thomas to look at the process of Medical Records and Medical Records Management.	**A Mulvey**	October 2011 Update Feb 2012	**COMPLETE**
GC88/11(d)	**Medical Division –** Clinical Audit Programme/Internal Audits – Division to provide an exception report to the Committee on this.	**B Monk**	Jan 2012	**COMPLETE – Agenda item**
November 2011				
GC95/11(b)	**Medical Devices –** CS, RD & AD to meet to ensure structure in place. Update to be brought back to the February 2012 Committee.	**C Siddall, R Duguid & A Davidson**	Feb 2012	**COMPLETE**
GC99/11	**Minutes –** **1 Safeguarding Board –** Terms of Reference to be brought to the Governance & Quality Committee for ratification. **2 Emergency Preparedness SG –** AD to speak to CS with regards to the Terms of Reference for the	**C Platton** **A Davidson & C Siddall**	Feb 2012 Dec 2011	**Deferred until March 2012** Meeting has been re-scheduled for 05/03/2012. Outcome to be reported to meeting in March 2012.

Minute Point Reference	Details of Action Agreed	Action by whom	Target Date	Progress
	Group. For representation at December 2011 meeting			
Dec 2011				
GC107/11(b)	**Action: CAS Alerts –** **1** AD to request CAS information is included in Divisional Reports.	**A Davidson**	Jan 2012	**COMPLETE** HK meets with John Mitchell monthly to review all CAS alerts and will arrange for the data to be available for each ¼ divisional; report to G&Q Committee
GC107/11(c)	**Health & Safety Update –** AD to agree timescales and circulate the update round the Governance & Quality Committee	**A Davidson**	Jan 2012	**COMPLETE –** see Appendix A
GC107/11(d)	**Security Plan – Action: Security Plan – Update –** 1 AD to check 11.1 to see if related to Baby Tagging or if related to the new build. Then the updated document to be circulated to Governance Committee Members. 2 Action plan to be updated to ensure clarity on items which link to the new build. 3 AD to send Operational Policy to RD.	**A Davidson**	Jan 2012	**COMPLETE** - See Appendix B **COMPLETE** – See Appendix B **COMPLETE –** sent to RD, 22 February 2012.

Minute Point Reference	Details of Action Agreed	Action by whom	Target Date	Progress
GC109/11(h)	**H & S Committee Minutes –** AD to arrange for the Action Plan to be updated.	**A Davidson**	Jan 2012	**COMPLETE** – Agenda item
January 2012				
GC 4/12 (a)	**Policy Resume** – RD & HK to check if the Governance & Quality Committee are ratifying documents which have already been approved by the TPG.	**R Duguid & H Kelly**	Feb 2012	**COMPLETE** The policy resume paper presented to Governance & Quality Committee is for information and to note the policies/documents that have been approved at Trust Policy Group.
GC 6/12 (a)	**Medical Divisional Report**			
	1 IST visit – CS to bring IST report and recommendations to the Governance Committee in February 2012.	**C Siddall**	Feb 2012	**COMPLETE**
	2 Escalation Plan for A & E to be report in the next Divisional report.	**B Monk & L Anderson**	April 2012	
	3 LA to feedback to RD the incident referred to on page 53 of report	**L Anderson**	Feb 2012	Verbal feedback to be given at March 2012 meeting
	4 CP to discuss the Inpatient Survey questions/answers with the Senior Nursing Team.	**C Platton**	Feb 2012	**COMPLETE** - the questions within the survey have been reviewed and the answer options have been expanded to ensure a clearer outcome.
	5 An update to be given in the next Divisional report with regards to AQ	**B Monk**	April 2012	

Minute Point Reference	Details of Action Agreed	Action by whom	Target Date	Progress
	issues and how these are being dealt with.			
GC 6/12 (b)	**Surgical Divisional Report –**			
	1 CS & CP to discuss standardisation of documentation.	**C Siddall & C Platton**	Feb 2012	**Ongoing** - Meeting arranged to finalise the initial discussions update required for March 2012.
	2 AY to provide VB with an explanation of "spells 1" and "spells 2".	**A Yarnold**	Feb 2012	AY to clarify the detail required with VB.
	3 Next divisional report to provide consistent approach in the way the Divisions look at mortality and morbidity.	**Divisions**	April 2012	
	4 Divisions to follow guidelines and policies with regards to incidents re: escalation and outcomes within the Divisions.	**Divisions**	April 2012	
	5 AY to provide further details on Guidelines/Policies not being followed and how this is being looked at in the Division, in the next quarterly report.	**A Yarnold**	April 2012	
	6 Formal feedback to be given on the following incidents: Page 69, reference 9342; page 71, reference	**Division**	April 2012	

Minute Point Reference	Details of Action Agreed	Action by whom	Target Date	Progress
	9934; page 71, reference 8550. 7 Further information on day case patients who require an overnight stay to be included in the next report.	**Division**	April 2012	
GC 6/12 ©	**Family Services/Clinical Support Division –** 1 NPSA Alert – BG to confirm when Trust will be compliant with NPSA alert. 2 TOPs – SP to confirm to RD date when single protocol in place. 3 External Visits – Division to provide reports on the outcomes of CNST and QUARC visits. 4 Complication rates – SP to include update in the next divisional report.	**B Glendinning** **S Preston** **Division** **S Preston**	Feb 2012 April 2012 April 2012 April 2012	**COMPLETE**
February 2012				
GC10/12(a) 1	**Pillars of Governance –** RD to send JR a copy of the core pillars of governance with an explanation.	**R Duguid**	March 2012	**COMPLETE**
GC10/12(b) 2	**NPSA Alert –** JF to arrange for discussion at the CSSG with regards to NPSA alert on preventing fatalities from medication loading doses and Trust compliance with this.	**J Forlow**	May 2012	
GC12/12(a)	**New Core Mandatory Training**	**D**	May 2012	

Minute Point Reference	Details of Action Agreed	Action by whom	Target Date	Progress
	Requirements - It was agreed that the next report on mandatory training (May 2012) will be presented in a more user friendly way highlighting the key issues.	**Gallagher/B Hoyle**		
GC13/12 (a)	**Infection Prevention Report –** **1** With regards to Cdiff numbers, CG to report in more detail on the next report, along with comments from the RCAs. **2** RD to include an exception report on Incident in the next report.	 **C Graham** **R Duguid**	 March 2012 March 2012	 Included in next report. Verbal update to be given at March 2012 meeting.
GC13/12(c)	**Medical Devices Update –** AD to bring a more details report the March 2012 Governance & Quality Committee.	**A Davidson**	March 2012	**Agenda item**
GC13/12(d)	**IST Visit –** CS to attend a Patient Panel meeting to talk through patient safety with the Patient Panel members.	**C Siddall**	April 2012	
GC13/12(f)	**Complaints -** HK to bring evidence of improved performance back to the April 2012 Governance & Quality Committee.	**H Kelly**	April 2012	
GC15/12	**Corporate Records Management –** AMU to meet with PW to ensure we are doing everything we possibly can to meet targets.	**A Mulvey**	March 2012	
GC16/12(f)	**Health & Safety Committee –** AD to arrange for the action plan to be updated	**A Davidson**	March 2012	**Agenda Item**

Minute Point Reference	Details of Action Agreed	Action by whom	Target Date	Progress
	before the next Governance & Quality Committee.			