North Cumbria University Hospitals
NHS Trust

MINUTES OF THE GOVERNANCE & QUALITY COMMITTEE HELD ON 25 SEPTEMBER 2012 AT 1:30 PM VIA VC USING BOARDROOM, WCH

Present: Michael Bonner, Non Executive Director (MB)
Vicki Bruce, Non Executive Director (VB)
Judith Cooke, Non Executive Director (JC)
Chris Platton, Acting Director of Nursing & Quality (CP)
Carole Jordan, Patient Panel (CJ)
Mike Walker, Medical Director (MAW)
Jessica Riddle, Patient Panel (JR)
Bill Glendinning, Head of Pharmacy (BG)
Alan Davidson, Director of Estates (AD)
Margaret Bailey, Patient Panel (MBa)
Kathy Barnes, Interim Head of Governance
Clive Graham, AMD, Clinical Support (CG)

In Attendance: Gillian Hetherington, PA
Simon Raimes, Deputy Medical Director
Liz Moloney, Head of Education & Training
Paul Wiggins, Deputy Director IM&T

GC62/12 WELCOME AND APOLOGIES FOR ABSENCE

MB noted that the Committee was quorate.

Apologies for absence were received from Anne Musgrave, Alistair Mulvey, Damian Gallagher, Gail Ferrier

GC63/12 MINUTES OF THE LAST MEETING

The minutes were accepted as a true record.

GC64/12 MATTERS ARISING AND ACTION PLAN

GC50/12(d) – Complaints Handling

CP asked if this paper could be withdrawn from the agenda. She explained that both Caroline Griffiths and Helen Kelly had been seconded to other Trusts and that Kathy Barnes (KB) had just taken over as Interim Head of Governance. This report needs to be reviewed by KB and CP will then update the Trust Board in

October 2012. The Governance & Quality Committee **AGREED** to withdraw this paper from the agenda.

GC65/12 COMPLIANCE & REGULATION

(a) Policy Resume

CP presented the Policy Resume to inform the Governance & Quality Committee of the guidelines, the policies, the protocols and procedures ratified at Trust Policy Group since last report in July 2012.

Policies

Appraisal & KSF Policy (HR) – Review
Bank Booking Policy (NC) – Review
Offsite Use of Information & Mobile Computers Policy (IG) – Review
NHS Number Policy (NC) – Review
Information Incident Reporting Policy (IG) – Review
Information Security Policy (IG) – Review
Long Service Award Policy (HR) – Review
Policy for Non-Medical Referrers & Radiological Opinion © - Review

Guideline/Procedure/Framework/Plan

Overseas Visitors Charging Regulations Procedure (IG) – Review
PAS Application; Birth Registration Procedure (NC) – Review
Interim Records Management Strategy (IG) – Review
Flexible Working Policy & Procedure (HR) – Review
Information Risk Policy (IG) – Review

The Committee **NOTED** the approved documents.

CP then went on to discuss Appendix 2 of the report – Out of Date Policies. She explained that there is a need to look at the process we have of reviewing our policies, to make this process more robust and to this end CP would like the Out of Date Policies rag-rated, so that it is possible to see immediately which policy we need to be focussing on.

VB queried that this Appendix raises some questions as to whether the policies have been completed.

MB expressed concern, as 2/3rds of policies appear to be out of date and felt that the Committee were promised much more information than has come in this report. CP **AGREED** to speak to MB outside the meeting.

Action: Out of Date Policies – CP to discuss with MB Out of Date Policies and information required by the Committee.

(b) Revalidation Update

Simon Raimes (SAR) attended the Governance & Quality Committee to update the Committee on the Revalidation Plan.

He explained that Revalidation is the process through which the GMC will confirm that a doctor's licence to practise will continue. Since May 2011 we have been required to complete and submit an Operational Readiness Self-Assessment (ORSA) every 3 months and this has formed the basis of the ORSA Action Plan. The main work going on at the moment is around training; it is important that all the doctors in the Trust are trained so they are fully prepared for Revalidation.

SAR also informed the Committee that part of this work is around Quality Assurance, which is very much developing nationally at the moment. This will be brought back to the Governance Committee and Trust Board.

SAR went on to explain the present appraisal compliance.

VB commented that this is a very clear paper and pleased to see the detailed progress. She is concerned as there appear to be senior doctors who are not engaging in the appraisal system. SAR explained there are a group of doctors who do need support and are not likely to be a problem as this is down to workload. There are a very small group where it might be necessary to take a more formal route but it is our intention to try and work with them differently. JC asked if one of the reasons some of the doctors not engaging could be due to their imminent retirements. SAR did not think this to be the case, as most doctors keep their registration up even after retirement. JC also queried whether the Portfolios were on track. SAR explained that there are different ways of maintaining Portfolios. GMC have an electronic document on which you can store your information and the Trust is at the moment trying to persuade doctors to support the use of this system.

The Revalidation update was **NOTED** by the Committee and an update will be brought back in 3 months' time. MB thanked SAR for a very clear report.

Action: Revalidation – SAR to update the Committee in 3 months' time.

(c) CQC Evidence Monitoring Report

CP brought the CQC Evidence Monitoring Report to Governance & Quality Committee to update them on the Trust's position with compliance with the Care Quality Commission regulations and associated outcomes. It highlights the progress on Outcomes 14 and 11. She explained that there had been significant work across Maternity on both sites and in Penrith.

With regards to Provider Compliance Assessments (PCA), CP explained that we have a link in Northumbria, Neil Gibson, Head of Governance, who is working with Nadia Lucetti to provide advice and support.

JR queried with regards to Outcome 12 whether the reports about Interserve

cutting staff had had an effect on cleanliness in the hospital. AD explained that the hospital has to be cleaned irrespective of whether they use 8 or 10 cleaners. It has been noted that standards have fallen at CIC. Interserve have acknowledged that there are problems and they have given assurances they do have adequate resources in place. This is being monitored by the Trust. He confirmed that as recently as 3 weeks ago there were still concerns but last week we were seeing an improvement. AD did confirm, however, that there has been an unprecedented amount of sickness and absence. MB asked how the improvements had come about; it was confirmed that this was due to supervision on the shop floor. JR queried how long this could be maintained with people going off sick. AD assured the Committee that they had concerns which were raised with Interserve and an HMC independent assessor came in and acknowledged that Interserve needed to sort out the issues. The situation is now being monitored on a weekly basis.

CP confirmed that there have also been concerns with regards to the deep cleans and time taken for Interserve to respond to them. AD and Carol Johnston have drafted up a Business Case to be taken to SMT, in order that we have a more robust cleaning programme. Spray and glow tests are really important in this, as this is how we check the cleaning. The Infection Prevention team have been asked to monitor on Outcome 8.

With regards to Outcome 14, the Trust has declared non compliant since registration in April 2010, mainly due to concern around appraisal, mandatory training and issues arising from the national Staff Survey. VB commented that following the CQC visit to A & E, they have managed to get their Appraisal rate up to 100%; we need to get this out to other areas to show them that it can be done. CP confirmed that AMu had sent out a message to staff praising the A & E staff with regards to what they had achieved. This is positive reinforcement that it can be done.

LM explained that we have an ESR system, which was previously only used as a payroll system but is now being utilised as an HR vehicle also and will give alerts with regards to Appraisals, Mandatory training etc.

CP confirmed that everything which has been submitted to the CQC is being monitored through the Divisions and updates will be given in their exception reports to Governance at the next meeting on 13 November.

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

GC66/12 WORKFORCE GOVERNANCE

(a) Education & Training Update

LM attended the Governance & Quality Committee to present the above paper to update them on appraisal and mandatory training and to raise awareness to issues associated with Medical Education Provision.

She went through the Appraisal and Mandatory Training documentation and the

presentation on Education Services.

VB noted that Medical and Surgical Divisions results appear to be much lower than Family & Clinical Support Division percentages for both Appraisal and Mandatory. Training. JC queried that there is nothing to show what is being done to improve these percentages. LM said that Sisters on ward areas are all being given their own appraisal figures; JC commented that it would be helpful to have this information in the next report.

BG confirmed that the Divisional General Manager for Family & Clinical Support circulates all appraisal information in the Division and these appraisal figures are reported in the monthly meetings with CS and Directors. The Committee would like to be reassured that other areas are going to replicate Family & Clinical Support.

The Committee noted that with regards to Mandatory Training, there was a drop in July and August figures, so it will be interesting to see what next month's figures are. LM confirmed all Continued Professional Development (CPD) applications are approved by her and sent back to managers and individuals when they do not reach the minimum requirement.

VB queried the percentages, as some of the Mandatory training is over 3 years and some over 1 year. It is not clear from this report what the percentages cover, so at the moment this data is unhelpful as to where we stand. VB also raised concerns with regards to Manual Handling training in Estates, as it is currently sitting at 13%. AD **AGREED** to investigate this.

MB was concerned as we have been looking at this issue for several months and the numbers are not changing.

With regards to the Education Service presentation, VB informed the Committee that this has come about following a discussion she had with Gail Ferrier. VB explained that it is not clear from this presentation who is being trained and who is doing the training and we do need this to be clear in future reports eg:

- What we currently deliver;
- What we currently outsource;
- What e-learning packages we use.

She felt that we need to get a sense of what we are doing and who we are working with on Education and Training. LM **AGREED** to take this back to Gail Ferrier.

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

Action: Education & Training –

1 An update on what is being done to improve the percentages for Appraisals and Mandatory Training to be in the next Education & Training report.

2. The Governance & Quality Committee would like assurance from Medical & Surgical Divisions that they are replicating the way Family & Clinical Support Services deal with their Appraisal figures.
3. AD to investigate why the Estates department is sitting at 13% for Manual Handling training.
4. LM to speak to Gail Ferrier regarding who is being trained and who is doing the training.

GC67/12 CLINICAL STANDARDS, PATIENT SAFETY & PATIENT EXPERIENCE

(a) Infection Prevention Report

CG presented this summary report from the Infection Prevention Team for the period July to August 2012.

MRSA – 0

MSSA – Remains below trajectory

Cdiff – Remains below trajectory as of today sitting at 18 cases this year; most of the cases occur around the Elm Pavillion.

Measles Outbreak – There has been a significant outbreak of measles in the CIC area with 5 people being admitted to CIC. CG informed the Committee that extensive work has been carried out by Occupational Health staff to confirm all staff working in admission wards are immune.

Hand Hygiene – There has been a fall off in August and this will need to be followed up with clinical teams.

Pseudomonas from water samples taken on SCBU CIC – water testing of other augmented care areas is still pending at CIC. The Committee asked CG to provide them with an update on Pseudomonas in the next report.

VB queried with regards to Appendix 1, there are a number of areas where the target dates have not been updated and there is nothing to say what progress has been made. CG **AGREED** to update Appendix 1 for the next meeting.

MB with regards to page 5, 3.1.4 Outbreaks at CIC, where it states "identified that routine screening as per Trust policy had not been implemented" asked if there is an explanation for this. CG explained that guidance for screening came out for elective and emergency patients. It is essential that Emergency patients are screened. An audit has been carried out on Larch AB where it was found not to be the case but we have been given assurance that this will be addressed. CG did not have any information on whether they had been able to re-audit but will find out for the next report. The MRSA policy has been redrafted to make it clear to staff and more in line with what Northumbria do.

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

Action: IP report –

1. CG to update the target dates and progress in Appendix 1 for the next report.
2. CG to confirm to the Committee if a re-audit took place on Larch AB with regards to MRSA screening.

(b) Medical Equipment – Regulation 16 (Update)

AD presented the Medical Equipment – Regulation 16 report to the Governance & Quality Committee to update them regarding progress towards compliance with Regulation 16. He explained that Regulation 16, outcome 11 deals with safety, availability and suitable of equipment.

He explained that the Medical Devices Working Group has focussed on medical equipment and through this group full audits of equipment in use, in all wards and departments have been undertaken and an action plan developed to achieve full compliance to meet Regulation 16, Outcome 11. The work of the Medical Devices Working Group is now coming to an end and will be formally transfer to the Medical Devices Committee which will need to be clinically driven and well represented.

A business case is being prepared to benchmark Northumbria against our sites but we have been advised to change the scope of the Business Case to look at some of the initiatives we have rolled out in North Cumbria being transferred to Northumbria.

AD said there is still a need to keep an overview of the progress made. AD believes he can give full assurance with regards to procurement, education & training and nursing staff but does not feel he can give the same assurance as regards clinicians and this is an area which needs to be developed.

JC asked if we know we are compliant, do we have the basic information. AD confirmed that there is a record of every piece of medical equipment. The Trust Governance Team are working closely with the Head of Medical Engineering and other members of the Medical Devices Working Group and have assessed the current situation against the requirements of outcome 11 and have produced an evidence list against each standard. The Trusts own self assessment remains that we are not yet fully compliant with this standard but plans are in place to address all the identified areas of concern. JC asked when we will be fully compliant. AD suggested this is subject to engagement with medical staff but it is hoped we will be complaint by December 2012 or January 2013.

VB did not feel that the paper was structured. There are too many “buts” and “ands”. She felt that the paper needed to be more organised and there is a need to address the work which has been drawn up. AD said what he had wanted to emphasise was that a huge amount of progress has been made.

MB asked that Medical Devices be added to the questions for the Non Executive

Patient Safety Walkabouts which take place on a monthly basis. CP **AGREED** to do this.

CG asked what AD wanted from the Medical staff, as it is not clear. AD **AGREED** to meet with MAW and CG outside the meeting to discuss what is required.

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

Action: Medical Devices

1. CP to arrange for Medical Devices to be added to the questions for the Non Executive Patient Safety Walkabouts.
2. AD to meet with CG and MAW to discuss Medical staff input into Medical Devices.

(c) Complaints Handling Update

Deferred until December 2012 meeting.

(d) PEAT/Environment Report

AD presented the PEAT/Environment report to the Committee to advise them of the confirmed outcome of this year's annual Patient Environment Action Team (PEAT) assessment scores for WCH and CIC and to advise members of the changes to the PEAT process for 2013.

The results for this year were very good on both sites.

With regards to the changes to the 2013 process, AD explained that they will have a pilot exercise in October 2012 and the intention behind this is to learn from the 1st pilot.

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

(e) Trust Clinical Audit Programme Update

KB presented the above report to Governance & Quality Committee to update them on the final version of the Trust Clinical Audit Plan 2012/13. She explained that 2012/13 Clinical Audit Plan identifies priority audits which include National Institute of Health and Clinical Excellence (NICE), National Standard Framework's (NSF) and National and Regional Audit Projects. It is aimed at auditing clinical services in a full comprehensive array of specialities, divisions and hospital sites.
KB also explained to the Committee that the delay in getting this report to them was due to not having a Clinical Audit and Effectiveness Manager in post; the post has now been filled. One of the areas where there have been issues was around the feedback of results of the audits; the Divisions are now reporting the number of audits completed in the year via their Divisional reports to Governance.

VB queried whether it would be possible do to all of these audits in the timescales projected. KB said that some Divisions are keen to do more around the work they are already doing and this will come through in the Divisional Reports. VB replied that as long as lists we have are owned by the Divisions they will be delivered. KB said that none of the audits have been chosen by Clinical Audit; they have come through from the Divisions.

JC felt this to be a helpful report. There are some areas where there is no clinical audit and some areas where it is being taken forward. This must be an issue for clinicians' portfolios; she asked if this had been joined with the Revalidation exercise. KB confirmed that this is right, in some national audits there is no audit lead identified; these have been passed back to the Divisions.

KB stressed that there is work to do but that they are much further forward than last year. JC asked if we are now linking up better and is this part of the improvement we will see as part of this work. CP explained that there needs to be engagement, there is really tight control on this, certainly from a nursing perspective.

LM said that there are a number of staff going through their Master's and they should be feeding back their dissertations. She felt it would be useful to contact these people so that they can share the information they have.

JC asked if the Clinical Commissioner groups see these lists. CP confirmed that they are within our Quality Account, so they are shared.

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

Action: Clinical Audit Plan – KB to contact staff currently doing Master's with a view to sharing information.

(f) Rule 43 (Dermatology Update)

This was an action from the July Governance Committee for a report to be submitted to Governance Committee in September 2012. As no report either written or verbal had been forthcoming, CP was asked to feedback on behalf of the Committee, to the Division, that a report was to go the SMT and then a summary to come back to the next Governance & Quality Committee.

GC68/12 INFORMATION GOVERNANCE

(a) IG Report

PW presented the first of the requested monthly update reports to the Committee to advise them of the action being taken to comply with the Level 2 evidence for each applicable V.10 Information Governance Toolkit Requirement. The key points were:

1) Other than the required updating of Level 2 or Level 3 evidence submitted last year, the focus is on the 3 Requirements which were self assessed as Level 1 in March 2012 and which is a key issue in respect of Acquisition;
2) In respect of staff training (IG112) monthly performance figures by Division and Directorate are reported and the overall percentage included in performance packs;
3) In respect of Corporate Records Management (IG601 IG604) an action plan has been prepared for approval by the Executive Management Team;
4) It was expected that some Requirements self assessed at Level 2 in 2011/2 would have supporting evidence for Level 3 in 2012/3, all subject to Internal Audit review.

BG reported that there was an issue with accessing e-learning within a 12 month period but in different financial years - as was required to comply with IG112. PW agreed to investigate and report back to him

The Committee **NOTED** the report and MB thanked PW for presenting it.

Action: IG Report –

1 An update to come to Governance & Quality Committee on a monthly basis.
2 PW to investigate issue with accessing e-learning within a 12 month period.

GC69/12 STANDING ITEMS

(a) Minutes/Actions of Meetings

The Chairman stated that it was established sometime ago that we would take minutes as early as possible after the meeting, even unratified minutes, in order that the Committee is kept informed. This appears to have slipped back again as we have again received a set of minutes from May 2012. Reminders to be sent out again.

- **Emergency Preparedness Steering Group** – The Committee **NOTED** the minutes.
- **Drugs & Therapeutics Committee –** The Committee **NOTED** the minutes.
- **Health & Safety Committee –** There was a query with regards to page 6 of the minutes re: Water Safety Group. From the text of the minutes it could be perceived by someone outside the Trust that we have only been water testing for 3 years.

GC70/12 ANY OTHER BUSINESS

(a) Governance Improvement Plan

CP presented the Governance Improvement Plan to the Committee to update them on the current status of this plan. She explained that in January 2011 the Trust Board had approved specific terms of reference for the review of clinical governance.

She asked the Committee to note that there had been an increase in amber and red status. This was due to the CQC inspection and our Trust's position on appraisals, mandatory training and appraisals for locum staff. KB, MAW and CP have reviewed this and it has been updated to reflect where we are at the present time. Mandatory training has a Red status and is a significant challenge to the organisation. There is no evidence with progression currently across the Trust and this also applies to appraisal. The Trust Board will be monitoring this and the Interim CEO has confirmed that the Trust will aim to achieve 100% for staff in mandatory training and appraisals.

VB feels that we need to get to a much more realistic position than our previous set of forecasts. CP stated that we also need to include the Due Diligence work as well as it is ongoing assurance and assessment. JC noted that there are still target dates to scrutinize and some thought needs to be put into the next report. CP confirmed that with regards to the dates, they are the original target dates set. She confirmed that she will be taking an updated report to Audit Committee in November and then Trust Board.

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

(b) Interim Head of Governance

CP introduced Kathy Barnes (KB) to the Committee, she has taken on the role of Interim Head of Governance and Clinical Governance.

GC70/12 DATE & TIME OF NEXT MEETING

The next meeting will take place on **Tuesday, 13 November at 1.30 pm in the Boardrooms WCH. Please note this is the Divisional meeting which is a face to face meeting.**

North Cumbria University Hospitals NHS Trust

GOVERNANCE & QUALITY COMMITTEE ACTION LIST – JULY 2012

DATE OF MEETING: 25 September 2012

Minute Point Reference	Details of Action Agreed	Action by whom	Target Date	Progress
January 2012				
GC 6/12 (b)	**Surgical Divisional Report –** 1 CS & CP to discuss standardisation of documentation.	**C Siddall & C Platton**	Feb 2012	Ongoing – working with Divisions on how to standardise report.
March 2012				
GC22/12(b)	**CQC Evidence Monitoring –** HK to ensure that the action plan is updated and more detail is provided in the next report in order to give greater assurance.	**H Kelly**	Sept 2012	**COMPLETE – Agenda item**
GC24/12©	**PEAT/Environment Report –** 1 Future PEAT/Environment Report to include action plans.	**A Davidson**	Sept 2012	**COMPLETE – Agenda item**
GC27/12(b)	**Integrated Governance Framework for Emergency Flow and Paediatrics –** CS to bring this framework back to the Committee in July 2012.	**C Siddall**	Dec 2012	An update to be brought to the December Governance Committee.
May 2012				

Minute Point Reference	Details of Action Agreed	Action by whom	Target Date	Progress
GC39/12(a)	**Out of Date Policies –** CP to speak to HK with regards to Out of Date Policies. This information needs to come to Governance on a quarterly basis with a summary with realistic timescales of the delays and where there are concerns	**H Kelly/C Platton**	Sept 2012	**COMPLETE – Agenda item.**
GC40/12(a)	**Staff Survey Report –** 1 For the next report, IE to ensure that the information be even more broken down into units not just sites. 2 ID to provide commentary on the 156 points in the next report.	**I Edgar** **I Edgar**	Nov 2012 Nov 2012	
June 2012				
GC49/12(a)	**Equality & Diversity Report –** Update to be brought to the Committee in December 2012.	**D Gallagher**	Dec 2012	
GC50/12(c)	**Action: Regulation 16** **1** AD to provide CG with a draft action plan prior to the scheduled meeting with Northumbria on 27 June 2012. **2** AD to provide an update report to the Committee in September 2012.	**A Davidson** **A Davidson**	June 2012 Sept 2012	**COMPLETE** **COMPLETE – Agenda item**
GC50/12(d)	**Complaints Handling -** An updated report to be brought to the September 2012	**H Kelly**	Sept 2012	Agenda Item - withdrawn from the meeting. Ongoing – to be reviewed by KB and CP to

Minute Point Reference	Details of Action Agreed	Action by whom	Target Date	Progress
	Governance & Quality Committee that includes the outcome of the review by CG			then update the Trust Board in October.
GC52/12 (a)	**Governance Improvement Plan –** CG to bring updated report back to the September 2012 Governance & Quality Committee.	**C Griffiths**	Sept 2012	**COMPLETE – Agenda item**
July 2012				
GC59/12(a)	**Surgical Divisional Report –** Division to review report format and include assurance.	**L Corlett**	Oct 2012	
GC59/12(b)	**Family & Clinical Support Services Divisional Report**			
	1 SP to amend the report and reissue to the Governance Committee.	**S Preston**	Aug 2012	**COMPLETE**
	2 Caesarean section surveillance – An update to be given in the next report with regards to the completion of paperwork.	**S Preston**	Oct 2012	
	3 Medical Devices Alert 202/037 – HK to check why this is in Red and report back to the Committee.	**H Kelly**	Sept 2012	**Ongoing –** CP to speak to AD.
	4 Divisions to review report format and include assurance (see Surgical Division report for detail)	**S Preston**	Oct 2012	
GC59/12(c)	**Medical Divisional Report**			
	1 Update to be given in the next	**B Monk**	Oct 2012	

Minute Point Reference	Details of Action Agreed	Action by whom	Target Date	Progress
	Divisional report with regards to action plan from CQC visit.			
	2 Pain Management – LG to arrange for this to be added to the Divisional Performance agenda and SMT agenda. It will also be reviewed at the next Divisional Governance Committee.	**L Gorley**	Oct 2012	
	3 Division to provide report on Rule 43 to the next Governance & Quality Committee in September 2012.	**B Monk**	Sept 2012	Report to be submitted to SMT and brought to GC at next meeting.
	4 DC to find out the current appraisal rates for A & E and report back to the G & C Committee.	**D Collins**	Sept 2012	**COMPLETE**
	5 Divisions to review report format and include assurance (see Surgical Division report for detail)	**B Monk**	Oct 2012	
GC60/12(a)	**IG Report –** An update to come to Governance & Quality Committee on a monthly basis.	**P Wiggins**	Sept 2012	**COMPLETE**
Sept 2012				
GC65/12(a)	**Out of Date Policies –** CP to discuss with MB Out of Date Policies and information required by the Committee.	**C Platton**	Nov 2012	
GC65/12(b)	**Revalidation –** SAR to update the Committee in 3 months' time.	**S Raimes**	Jan 2013	
GC66/12(a)	**Education & Training –**			

Minute Point Reference	Details of Action Agreed	Action by whom	Target Date	Progress
	1 An update on what is being done to improve the percentages for Appraisals and Mandatory Training to be in the next Education & Training Report.	**L Moloney**	Jan 2013	
	2 The Governance & Quality Committee would like assurance from Medical & Surgical Divisions that they are replicating the way Family & Clinical Support Services deal with their Appraisal figures.	**B Monk & L Corlett**	Nov 2013	
	3 AD to investigate why the Estates department is sitting at 13% for Manual Handling training.	**A Davidson**	Nov 2013	
	4 LM to speak to Gail Ferrier regarding who is being trained and who is doing the training.	**L Moloney**	Jan 2013	
GC67/12(a)	**Infection Prevention Report –**			
	1 CG to update the target dates and progress in Appendix 1 for the next report.	**C Graham**	Nov 2012	
	2 CG to confirm to the Committee if a re-audit took place on Larch AB with regards to MRSA screening.	**C Graham**	Nov 2012	
GC67/12(b)	**Medical Devices – Regulation 16**			

Minute Point Reference	Details of Action Agreed	Action by whom	Target Date	Progress
	1 CP to arrange for Medical Devices to be added to the questions for Non Executive Patient Safety Walkabouts. **2** AD to meet with CG and MAW to discuss Medical staff input into Medical Devices**.**	**C Platton** **A Davidson**	Oct 2012 Nov 2012	
GC67/12(e)	**Clinical Audit Plan –** KB to contact staff current doing Master's with a view to sharing information.	**K Barnes**	Nov 2012	
GC68/12	**IG Report** – 1 Update to come back to November 2012 meeting. 2 PW to investigate issue with accessing e-learning within a 12 month period.	**P Wiggins** **P Wiggins**	Nov 2012 Nov 2012	