North Cumbria University Hospitals NHS
NHS Trust

UNRATIFIED MINUTES OF THE GOVERNANCE & QUALITY COMMITTEE HELD ON 31 JULY 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)
Alistair Mulvey, Director of Finance/Deputy Chief Executive (AMu)
Caroline Griffiths, Director of Acquisition & Strategic Planning & Acting Director of Governance (CG)
Damian Gallagher, Director of HR (DG)
Helen Kelly, Head of Patient Safety and Clinical Governance (HK)
Mike Walker, Medical Director (MAW)
Corinne Siddall, Director of Operations (CS)
Jessica Riddle, Patient Panel (JR)
Bill Glendinning, Head of Pharmacy (BG)

In Attendance:
Gillian Hetherington, PA
Stephanie Preston, DGM, Family & Clinical Support Services (SP)
Claire Moore, HoN, Family & Clinical Support Services (CM)
Denise Lightfoot, Matron, Maternity (DL)
Lynne Gorley, Business Manager, Medical Division (LG)
Davina Collins, Sister, A & E, CIC (LG)
Louise Corlett, DGM, Surgical Services (LC)
Richard Heaton, HoN, Surgical Services (RH)
Ann Yarnold, Governance Facilitator, Surgical Services (AY)

GC54/12 WELCOME AND APOLOGIES FOR ABSENCE

MB noted that the Committee was quorate.

Apologies for absence were received from Alan Davidson, Margaret Bailey, Anne Musgrave, Kathy Barnes, Barbara Monk, Lynn Anderson, Clive Graham, Patrick Armstrong.

GC55/12 MINUTES OF THE LAST MEETING

The minutes were accepted as a true record.

GC56/12 MATTERS ARISING AND ACTION PLAN

GC50/12(d) – Complaints Handling

JC queried whether we have two tiers of complaints. HK replied that with regards to responding within 25 days, there is nothing to say it has to take that long and some do not; it is complexity of the complaint and the consequent investigation which influences the response time. She confirmed that complainants are now mostly being contacted by telephone when complaints come into the Trust. HK explained that in respect of Northumbria's Complaint Policy, meetings have been set up between the Governance Facilitators from both Trusts.

CG explained that we need assurance around actions of complaints in relation to lessons learned and preventing the issues reoccurring. MB stressed that we have to bear in mind that where complaints are genuine, we need to be seen to to deal with their concerns promptly and make the necessary improvements.

GC27/12(b) – Integrated Governance Framework for Emergency Flow and Paediatrics

With regards to this action CS gave an update to the Committee. She explained that there is a draft integrated Governance Framework for the Integrated Emergency Floor, which had been reviewed again at a meeting that morning and following the meeting there are some changes which need to be made. Once these changes have been made and agreed, the document will then need to go to the System Wide Board. The document has to be approved by 3 organisations and CS will let the Committee know when the Framework is ready to be submitted as a formal report.

MB stated that it is the Framework that we have asked to see. The actual management behind it needs to be agreed as to how it looks as an entity. We need to make sure this is right the first time.

JR queried whether, as it is such a big piece of work; it would not be advisable to have some kind of discussion with Northumbria. CS confirmed that they have already given a presentation to colleagues in Northumbria, so this is something they are aware of. They understand the concept of an integrated emergency floor and they understand in great detail the work which is being done at present.

MAW explained that it is important to recognise that getting the Governance Framework across different systems has been a challenge for the Health Services. People fall foul of the system as they move from one system to another. It is imperative that we have a system like this in order to cross boundaries.

MB queried whether there is anything in our present agreement with the acquiring Trust which says they have to be involved. CG explained that in relation to the Framework, they expect us to press ahead and progress this. If we wanted to start any other significant service change, which was not in the programme, then they would need to be consulted.

GC57/12 COMPLIANCE & REGULATION

(a) Policy Resume

HK 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 May 2012.

Policies

Referral to Treatment and Waiting List Policy (NC) – Review
Flexible Working Policy and Procedure (HR) – Review
Grievance Procedure and Policy (HR) – Review
Bleep Policy (c) - Review
Consultant and SAS Grade Annual Leave Policy (HR) – Review
Lockdown Policy (NC) – Review
Pest Control Policy and Procedure (NC) – Review
Recovery of Over Payments and Settling of Under Payments Policy and Procedure (NC) – New
Information Security Policy (IG) – Review
Management of Inpatient STF (c)- Review

Guideline/Procedure/Framework/Plan

Acting Down Procedure for Consultants (HR) – Review

Maternity Guidelines

Caesarean Section v10 – Review

The Committee **NOTED** the approved documents and MB thanked HK for presenting them.

GC58/12 CLINICAL STANDARDS, PATIENT SAFETY & PATIENT EXPERIENCE

(a) Infection Prevention Report

CP presented this summary report from the Infection Prevention Team for the period June – July 2012.

Outbreaks – There have been 3 cases of Cdifficile attributed to Elm C in the last 2 months (2 with links to Elm A). Clinicians, IP Team and Interserve have been working together with regards to cleaning and because of this outbreak the Infection Prevention Team have been in discussions with the HPA.

With regards to the MRSA Colonisation (CIC) – Patients were routinely screened and what was identified was new colonisation via nasal swabs. Patients were put on eradication treatment and whole ward was screened.

Hand Hygiene – CG queried the dip in hand hygiene percentages at the beginning of the year and asked if this was being addressed. CP confirmed that the Infection Prevention Team and Heads of Nursing are looking at this in their clinical areas. It is also being picked up as part of the Safety Thermometer work; CP has been assured by Infection Prevention that this will be sorted by September 2012. CG suggested that a minimum standard should be set.

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

GC59/12 DIVISIONAL REPORTS

(a) Surgical Division

LC, RH & AY attended the Governance & Quality Committee to present the Surgical Divisional Report to summarise the governance and quality activities undertaken within the Surgical Division between April and June 2012. The aim of the report is to provide assurance to the Committee by describing service improvements, lessons learned, patient experience and risk issues using the pillars of governance model.

They gave a presentation (attached) detailing:

- Governance, Risk & Quality
- Compliance and Regulations – Compliance regarding national and local indicators
- Standards, safety and experience
- Divisional Audit programme
- Risk Management
- Workforce Management
- Information Governance
- Governance challenges for next quarter

Ophthalmology & Oral Surgery - LC explained that there have been huge challenges around delivering Ophthalmology within the 18 week timescale. The Division has been working with external providers and it is anticipated that by the end of July they will be compliant. She confirmed also that Oral Surgery is also now compliant and they hope to achieve 95% from now onwards; a lot of work has gone into this.

Mortality – AY reported on mortality and explained that the chart illustrates rolling risk adjusted mortality for the Surgical Division for the past 2 years. The comparators used are CHKS and Health Episode Statistics (HES) and felt it encouraging that NCUH is not an outlier.

VB expressed concerns with regards to overall Mortality as this has been questioned by Northumbria.

MAW explained that we have to be more careful we do not choose one measure. Comparing our RAMI with HMSR that Northumbria has as a peer group; we are

very much better than Northumbria in straightforward mortality, worse with RAMI and also same with SHIMI. The bottom line is that measures are all developing and to put up one indicator and draw one conclusion is not appropriate.

VB suggested that she would like a complete chart as an A4 briefing sheet. This would show where we are with this measure compared with Northumbria. MAW confirmed to VB that she will get this at the next Trust Board meeting on the 15 August 2012.

CG explained that this has been reviewed and there will be a lot of work required on this over the next 2 months prior to the publication of the Dr Foster report. She explained that we need to look at both clinical and process issues, which include information and how it is interpreted and used; from completeness of coding perspective, there are some significant omissions in this at the moment. We have got to review all the cases from last year and assure ourselves and non executive directors where the issues lie and to what extent they are clinical or process issues.

VB expressed concern that the Governance Committee should be concerned about Mortality; particularly as the prospective new partners think this is a significant issue and what we have at the moment is an unclear position. CG agreed that this section of the Surgical Divisional report is confusing and agreed with the comments made by VB. It is necessary to pull all 3 indicators together and explain what they mean. She confirmed that the Surgical Division will be involved in the review.

MAW explained that we have no option but to take the figures from Dr Foster extremely seriously. For whatever reason we are an outlier and this is the basis that is driving the action which non executives will get sight of shortly. He assured the Committee that we will get quality information over the next few months.

MB read from the NHS Centre of England report which focuses on:

- Mortality
- Staff Survey Numbers
- Mixed Sex Accommodation

So he feels it is right and proper that we have these discussions.

MAW confirmed that so far we have not picked up any real evidence of poor quality care; VB believes this is what will be found. There is also no evidence that shows our record keeping is poor.

AMu requested that the Committee should not draw assurance from the graph on the Surgical Mortality rates as we cannot be assured using one set of data.

MAW commented that there are definite issues in the way we are handling the data, particularly Palliative Care data, more related to the West Cumbria population. CG explained that Northumbria have been involved in scoping out work and they are satisfied we are going about this in the correct way. It is

important to get all administration information correct for the future. We have a responsibility to patients' and their relatives to provide this level of assurance.

Risk Management – RH explained that a lot of the incidents are around long term sickness in the Division and in comparison they have very small amount of short term sickness. There have also been issues around staffing, often unable to fill gaps due to short term sickness.

Workforce Management – RH explained that with regards to short term sickness, this is being managed. Long term sickness is proving more difficult at the moment. JC asked with regards to staffing pressure, lost 189 hours due to long term sickness; she wondered if there was evidence to show that this is dangerous. RH replied that they have flexed staff to ensure skill mix is appropriate in all areas, so it is not dangerous at all. She also asked if there is any apparent link to Slips, Trips & Falls but this is not the case.

CG asked when we can realistically see non consultant appraisal rates of 80% and is that a target we can achieve. RH explained that there is a huge drive at the moment with sisters trying to spread appraisals over the year rather than in just a 6 month period. It is hoped that there will be a significant improvement in the next 12 months but he does feel that 80% is a figure that can be achieved.

CG offered a couple of suggestions to the Surgical Division for future reports:

- **High Level Incidents** – Closure and lessons learned; adopt this style for each of the areas, as this will confirm or not.
- **Conclusion** – Provide a summary of the key risks within the Division and describe how these are being managed.

CG asked that all the Divisions take these suggestions on board for future reports.

VB commented that the Surgical Division report was very good and very clear, a very much improved report. She also noted that the staff and patient experience data looks very positive.

The Committee **NOTED** the report and MB thanked the Division for presenting a much improved report.

Action: Surgical Divisional Report

Divisions to review report format and include assurance.

(b) <u>Family & Clinical Support Services Divisional Report</u>

SP, DL & CM attended the Governance & Quality Committee to present the Divisional report to summarise governance activities undertaken within the Family & Clinical Support Division between April and June 2012. The aim is to provide assurance to the Committee by describing service improvements, lessons learned, patient experience and risk issues using the Pillars of Governance Framework.

SP started by apologising to the Committee that the report had not been ratified by the Division due to sickness. SP offered to look at the report, amend it and reissue to the Governance Committee. This was **AGREED**.

SP then went on to give a presentation (attached).

BG explained that there had been an unannounced visit to the A & E Department at CIC which encompassed an inspection of the medicines management standard. One of the issues they had was around an unlocked medicines cabinet. He explained that it is necessary for this cabinet to be unlocked for Resuscitation purposes; but the main issue was around where it was placed, it has now been relocated. The CQC also asked the Division to undertake a medicines security audit, this has taken place and been submitted to the CQC. There will be a re-audit later in the year with compliance being monitored via the Safe Medicines Practice Group

Following a previous CQC visit, where the formal report said we were compliant against standards but that the documentation regarding Termination of Pregnancy (TOPs) on both sites was not as robust as it could have been; an audit has taken place with the aim of ensuring that all Certificate A forms are completed in compliance with statutory regulation. This Audit has been led by an Obs and Gynae Consultant. SP confirmed that they had looked at 171 cases and in all cases we were 100% compliant on both sites, so the measures which were put in place have worked.

With regards to Caesarean section surveillance, page 8 of the report. VB expressed concern that the stats on some of these indicate that paperwork is not being done. SP confirmed that this true, she explained that the vast major of these cases are done for appropriate needs and if there are complaints or problems, and the paperwork is not complete, then this is an issue. This is an issue which Anne Musgrave, Head of Midwifery is focussing on at the moment. CP confirmed that it is also being monitored through the Infection Prevention Committee. This is not just a Family Services issue, as surgery involves anaesthetists, surgeons etc, it goes right across the board. An update on this issue will be given in the next report.

MB queried Medical Devices Alert 202/037, which is in red. SP not sure why and HK **AGREED** to look at this and report back to the Committee.

The Governance & Quality Committee **NOTED** the report and MB thanked the Division for their presentation.

Action: Family & Clinical Support Division

1 SP to amend the report and reissue to the Governance Committee.
2 Caesarean section surveillance – An update to be given in the next report with regards to the completion of paperwork.
3 Medical Devices Alert 202/037 – HK to check why this is in Red and report back to the Committee.
4 Divisions to review report format and include assurance (see Surgical

Division report for detail)

(c) Medical Division Report

LG and DC attended the Governance & Quality Committee to present the Medical Divisional Report to provide assurance to the Committee that governance, risk, lessons learned and subsequent service improvements have been implemented within the division to ensure patient safety and enhance the patient experience.

LG gave a very brief explanation of the report and then handed over to DC to give a presentation (attached) detailing the unannounced CQC visit on 13 June 2012.

DC explained the background to the presentation and then went on to detail the findings of each of the Outcomes. The results of the outcomes were as follows:

- Outcome 4 – Care & Welfare of people who use service – compliant
- Outcome 7 – Safeguarding people who use services from abuse – compliant
- Outcome 8 – Cleanliness and Infection Control – Non-compliant (Minor impact)
- Outcome 9 – Management of Medicines – Compliant
- Outcome 11 – Safety, availability and suitability of equipment – Non-compliant (Minor impact)
- Outcome 13 – Staffing – Compliant
- Outcome 14 – Supporting staff – Non-compliant (Moderate impact)
- Outcome 16 – Assessing and monitoring the quality of service provision – Non-compliant (Minor impact)

She went through all of these outcomes, explaining the reasons why we were non-compliant on some of the outcomes and what measures have been put in place to support these.

Outcome 8 - One of the issues where we were non compliant was “Storage and collection of clinical waste bags was a concern in respect of staff safety”. DC explained that at the time of the visit a collection was due within a short period of time and therefore no action was required. CG explained that we need to be aware that we could be revisited on any of these points. Where we have Interserve issues these must be addressed or escalated, if frequency of collection is not adequate, then this needs to be addressed.

Outcome 14 - JC raised an issue regarding staff meetings and asked why we have these, when no-one turns up. DC confirmed that they have daily meetings and these are well attended by both medical and nursing staff, but unsure why staff do not turn up at the monthly meetings. They do have to attend these in their own time as it is only possible to release 1-2 staff who are working to attend. CG asked DC what the current appraisal rate for staff is now and DC said she would have to find this information.

JC also stressed that there is also a need for formal clinical supervision, as CQC

say that this should be formal and recorded.

CG confirmed that Division has got to make sure action plans are particularly strong in this area, as it is a 'moderate' impact. Following the visit the Trust submitted further information to the CQC that demonstrated further compliance. However, the CQC reports on what they found on the day. HK confirmed that the action plan is owned by the department but that she is facilitating the development of it. HK advised that there needs to be an Executive Lead and Operational Lead. CS **AGREED** to be Executive Lead

JR felt that when the action plan is drawn up it would be useful to ask staff why attendance at monthly meeting is so low. DC agreed it would be helpful to ask staff what they felt would work with regards to staff meetings.

CG stressed that all actions need to be implemented without delay and that the department needs to evidence ongoing compliance against these standards. There can be no tolerance of outstanding issues, particularly in relation to the non-compliant standards.

The Clinical Indicator table on page 11 was discussed. It was suggested that the colour coding of the arrows be removed, with the direction of the arrow indicating an increased or decreased score. It was noted that Pain Management had been below target for all 3 months. Lynn Gorley was asked to arrange for this to be added to the Divisional Performance Review agenda and SMT agenda. This will also be reviewed at the next Divisional Governance Committee meeting.

CS informed the Committee that a new Medical Model is being introduced at Cumberland Infirmary on Wednesday, 1 August and at West Cumberland Hospital in September and the KPI's will be monitored weekly. CS does not anticipate any major impact until Emergency Flow Project in place. She also informed the Committee that they are not seeing any reduction in demand at the front door that was anticipated and we are still seeing even more attendance to A & E and EAU. This is not just a local pressure but regional and national pressure, which is being watched locally.

CG noted that there was an omission from this Governance report; this is with regards to assurance around Rule 43. The Committee asked if the Division could provide a written report on this to the September Governance Committee.

The Governance & Quality Committee **NOTED** the report and MB thanked the Division for a very interesting presentation.

Action: Medical Divisional Report

1. Update to be given in the next 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.
3. Division to provide report on Rule 43 to the next Governance & Quality

Committee in September 2012.

4 DC to find the current appraisal rates and report back them back to Governance & Quality Committee.

5 Divisions to review report format and include assurance (see Surgical Division report for detail)

GC60/12 INFORMATION GOVERNANCE

(a) IG Report

AMu presented the IG report the Governance & Quality Committee to advise them of the action being taken to ensure compliance with the achievement of Level 2. This paper highlights what we need to do to get IG compliance which is an essential compliance of the Acquiring Trust. He explained that it is intended to develop a monthly compliance report and dates need to be agreed with various Divisions and Departments at some point between middle of September 2012 and January 2013. It will also be incorporated into the Divisional Reviews in order to monitor compliance.

It is proposed to bring an update each month to the Governance Committee which highlights where we are with targets and also in terms of performance.

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

Action: IG Report – An update to come to Governance & Quality Committee on a monthly basis.

(b) Learning Disability Self Assessment Framework 2011

CP presented the NHS Cumbria's report to Governance Committee, to inform them of the implementation, completion and validation of the Health Self Assessment Framework for Learning Disability Services in Cumbria for 2011.

There followed a short discussion on this report and JC asked what the issues are for our hospital trust. It was explained that the issue is; are we happy that the patients who come through the doors are helped, supported and managed to the highest level. JC asked if we have any information with regards good practice or less good practice. CP replied that she did not have the answer; this is where we need to get to. She explained that Crea Simpson, Matron, Patient Experience is speaking to carers, patients and working with the staff. She has done a lot of work with passports; we now need to make the staff aware that extra time needs to be allocated eg in Outpatients. We are at the moment working on our own procedures.

An update is to be provided to the Trust Board in September 2012.

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

GC61/12 DATE & TIME OF NEXT MEETING

The next meeting will take place on **Tuesday, 25 September 2012 at 1.30 pm in the Boardrooms CIC and WCH. Please note the main body of the meeting will be at CIC.**

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 31/07/2012 – discussion regarding the detail of this action – January minutes to be reviewed for the detail.
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	
GC24/12©	**PEAT/Environment Report –** 1 Future PEAT/Environment Report to include action plans.	**A Davidson**	Sept 2012	
GC27/12(b)	**Integrated Governance Framework for Emergency Flow and Paediatrics –** CS to	**C Siddall**	2012	CS gave an update see July minutes, and **AGREED** to bring the report to the

Minute Point Reference	Details of Action Agreed	Action by whom	Target Date	Progress
	bring this framework back to the Committee in July 2012.			Committee when a formal document.
April 2012				
GC34/12(a)	**Medical Division:** **1 Mortality & Morbidity** to be reported in more details in the next report. **2 Vulnerable Adults Risk –** update to be given in the next report. **3 Risks –** only "RED" risks and risk that have reduced from or increased to "RED" during the quarter.	**Medical Division** **Medical Division** **Medical Division**	July 2012 July 2012 July 2012	**COMPLETE** **COMPLETE** **COMPLETE**
GC34/12(b)	**Family & Clinical Support:** **1 CQC National Inspection (TOPs) –** Audit results to be reported in the next report. **2 Mortality & Morbidity** to be reported in more details in the next report. **3 Risks –** only "RED" risks and risk that have reduced from or increased to "RED" during the quarter. **4 Generic Risks –** HK to discuss issues with the Division.	**Family & Clinical Support Div.** **"** **H Kelly** **Family & Clinical**	July 2012 July 2012 July 2012 July 2012	**COMPLETE** **COMPLETE** **COMPLETE**

Minute Point Reference	Details of Action Agreed	Action by whom	Target Date	Progress
		Support Div.		
GC34/12©	**Surgical Division:** **1 Mortality & Morbidity** to be reported in more details in the next report. **2 Risks –** only "RED" risks and risk that have reduced from or increased to "RED" during the quarter.	**Surgical Div** **"**	July 2012 July 2012	**COMPLETE** **COMPLETE**
May 2012				
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	**HK** gave assurance to the Committee that she would be dealing with all their questions in the report scheduled for the September meeting.
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	

Minute Point Reference	Details of Action Agreed	Action by whom	Target Date	Progress
GC41/12(a)	**Hand Hygiene –** CP to address the issue of no Hand Hygiene dispenser outside the Canteen at WCH.	**C Platton**	June 2012	**COMPLETE –** the Infection Prevention Team looking into this.
June 2012				
GC49/12(a)	**Equality & Diversity Report –** Update to be brought to the Committee in December 2012.	**D Gallagher**	Dec 2012	
GC50/12(a)	**Infection Prevention Annual Report –** 1 Typographical errors to be completed prior to going to TB. 2 Appendix 5 – check columns which have no rag rating and complete prior to going to TB. 3 Machines for checking if hands are clean or not to be placed, on occasions, in the foyers of both hospitals.	**C Graham**	July 2012	**COMPLETE** **COMPLETE** **COMPLETE –** at the next IP Awareness Day there will be a demonstration in the main entrances.
GC50/12(c)	**Action: Regulation 16** **6** AD to provide CG with a draft action plan prior to the scheduled meeting with Northumbria on 27 June 2012. **7** AD to provide an update report to the Committee in September 2012.	**A Davidson** **A Davidson**	June 2012 Sept 2012	Ongoing – CG to chase this up with AD.
GC50/12(d)	**Complaints Handling -** An updated report	**H Kelly**	Sept 2012	

Minute Point Reference	Details of Action Agreed	Action by whom	Target Date	Progress
	to be brought to the September 2012 Governance & Quality Committee that includes the outcome of the review by CG			
GC50/12(e)	**Security Management Annual Report -** AD to arrange for amendments to be made to the report and it then to be re-issued to Committee members.	**A Davidson**	July 2012	**COMPLETE**
GC51/12	**Minutes of Meetings -** Committee chairs and secretaries to be asked to ensure that minutes come to the Governance & Quality Committee in a timely manner. G&C should regularly receive a table listing all reporting committees, dates of meetings, and whether/when minutes of each have been submitted.	**H Kelly**	July 2012	**COMPLETE** – HK has written to all the Chairs of Committees.
GC52/12 (a)	**Governance Improvement Plan –** CG to bring updated report back to the September 2012 Governance & Quality Committee.	**C Griffiths**	Sept 2012	
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	**S Preston**	Aug 2012	

Minute Point Reference	Details of Action Agreed	Action by whom	Target Date	Progress
	to the Governance Committee. **2** Caesarean section surveillance – An update to be given in the next report with regards to the completion of paperwork. **3** Medical Devices Alert 202/037 – HK to check why this is in Red and report back to the Committee. **4** Divisions to review report format and include assurance (see Surgical Division report for detail)	**S Preston** **H Kelly** **S Preston**	Oct 2012 Sept 2012 Oct 2012	
GC59/12(c)	**Medical Divisional Report** **1** Update to be given in the next 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. **3** Division to provide report on Rule 43 to the next Governance & Quality Committee in September 2012. **4** DC to find out the current appraisal	 **B Monk** **L Gorley** **B Monk** **D Collins**	 Oct 2012 Oct 2012 Sept 2012 Sept 2012	

Minute Point Reference	Details of Action Agreed	Action by whom	Target Date	Progress
	rates for A & E and report back to the G & C Committee. **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	