Agenda item: 11
Enclosure no: TB2018/31

Buckinghamshire Healthcare NHS
NHS Trust

PUBLIC BOARD PAPER
MEETING – 28th March 2018

Details of the Paper

Title	Quality Report
Responsible Director	Tina Kenny, Medical Director Carolyn Morrice, Chief Nurse
Purpose of the paper	To update the board on performance against key quality indicators and continue the development of a refreshed quality report. The updated format was presented and discussed at the Quality Committee on 6th March. The report features a new section on indicators that the Care Quality Commission (CQC) insight reports contain about the trust.
Action / decision required (e.g., approve, note, support, endorse)	The Board is asked to note the quality report.

Links to BHT Business and Risks

Implications and issues to which the paper relates (please mark in bold)					
Patient Quality	Financial Performance	**Operational Performance**	Strategy	FT Application	New or elevated risk
Legal	**Regulatory/ Compliance**	Public Engagement /Reputation	Equality & Diversity	Partnership Working	Other
Annual Objective	High quality, safe and compassionate care in patients' homes, the community or one of our hospitals.				
Links to BHT Board Assurance Framework/Corporate Risk Register					
BAF/Corporate Risk Register Reference	This relates to a number of items both on the BAF and on the corporate risk register which stretch across the spectrum of the quality agenda.				
Risk Description					
Author of Paper					
Christine Skeldon, Head of Medical Quality and Development. Jo Atkins, Associate Chief Nurse					
Presenter of Paper					
Tina Kenny, Medical Director **Carolyn Morrice, Chief Nurse**					
Other committees / groups where this paper / item has been considered					
Quality Committee, 6th March 2018					
Date of Paper					
21st March 2018					

Buckinghamshire Healthcare NHS
NHS Trust

Trust Board
Quality Report
March 2018

Contents

Executive Summary

This is the March update of the trust's quality report, including the most up to date information and data available at this time. A number of measures show improvement, including the number of pressure ulcers, sepsis screening, patient safety incidents causing harm, maternity and neonatal indicators and surgery cancellations. Measures that have shown some decline include complaint response timescales and some of the Friends and Family Test indicators.

In comparison with the February trust quality report, pressure ulcers are showing an improvement. Whilst we aspire to further reduce the number of pressure ulcers, the total reported in February was substantially reduced. The services, of course, actively seek to decrease this further and a pressure ulcer summit was held in February to drive further improvements. All of the maternity and neonatal indicators have improved in February. This should be noted against the Care Quality Commission (CQC) Insight indicators, where the perinatal mortality rate data used is historic and subsequent extensive work has resulted in significant improvements.

Complaint responses within 25 working days were down to 78%. January saw a higher than average number of new complaints (51 Trust wide). In addition, system pressures impacted the ability to respond within target timeframes. The number of over 90-day complaints has gone up to 24 (from 19 the previous month).

Friends and Family Test responses in the Emergency Department have reduced to 8%, although the overall recommended score is up to over 90% (from under 82% in January).

The new mortality review programme continues to provide excellent feedback on many areas and is providing themes for learning, which are being fed back to clinical teams.

Section 1: Dashboards and Indicators

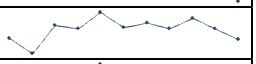
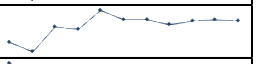
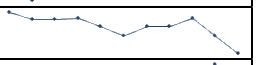
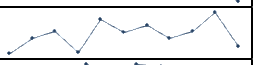
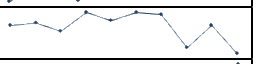
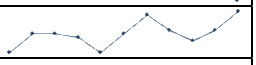
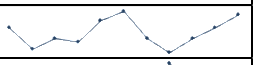
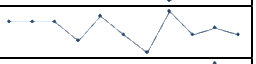
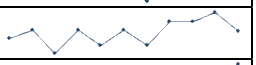
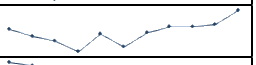
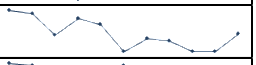
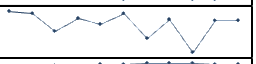
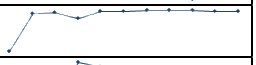
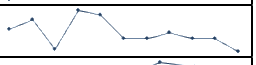
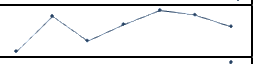
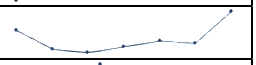
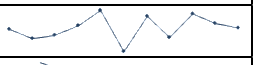
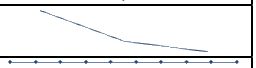
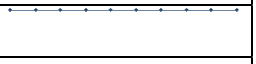
a) Main Dashboard

Key to ratings

Latest Data	Within or better than standard/ target		Slightly outside desired range but not significant risk	Outside of desired range and/or consistent trend away from range with associated moderate risk	Outside of desired range and/or consistent trend away from range with associated high risk
Change	No change	Positive change	Slight adverse change	Moderate Adverse change	High risk adverse change

Indicator		Date(s) of Latest Data	Standard / Target *(n = national)*	Latest Data	Change (from last data point)	Trend
Healthcare Associated Infection (HCAI)	Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia	Feb-18	0	0	⇩	
	Clostridium difficile infection	Year to date (to Feb)	Maximum 32 cases 2017/18 (n)	40	⇧	
		Feb-18	2	2	⇩	
	Peripheral line infection	Feb-18	0	0	⇔	
Sepsis	Sepsis screening in the emergency department	Jan-18	95%	90%	⇧	
	1 hour suspicion to needle time (STNT)	Quarter 3	Not set	88%	⇩	
	3 hour STNT	Quarter 3	≥ 95%	100%	⇧	
Patient Safety Incidents	Never Events	Feb-18	0 (n)	0	⇩	
	Overall percentage of patient safety incidents reported causing any level of harm	Feb-18	< 35%	28%	⇩	
	Medication incidents	Feb-18	Not set	93	⇧	
	Medication incidents causing moderate or severe harm	Feb-18	0	0	⇩	
Venous Thromboembolism (VTE)	VTE risk assessments	Feb-18	95% (n)	96.0%	⇩	
	Hospital Acquired Thromboses (HATs (Avoidable)	Dec-17	0	1	⇧	
Pressure Ulcers	Avoidable pressure ulcers, grade 2	Feb-18	< 18 per month	20	⇩	
	Avoidable pressure ulcers, grade 3 and 4	Feb-18	0	1	⇩	
Safety Thermometer	Overall Harm-Free Care	Jan-18	≥ 95%	91%	⇩	
Falls	Total number of reported falls	Feb-18	≤ 75 per month	102	⇧	
	Falls per 1,000 bed days	Feb-18	≤ 3.5	5.0	⇧	
	Falls with moderate or severe harm	Feb-18	≤ 2	4	⇧	
Cardiac Arrests	Number of cardiac arrests in non-critical areas	Feb-18	≤ 4	4	⇩	
Mortality	Hospital Standardised Mortality Ratio (HSMR) (Benchmarked against 2016/17)	Dec 16 - Nov 17	< 100 (n)	89.0	⇩	
	Standardised Hospital-level Mortality Indicator (SHMI)	Jul 16 - Jun 17	< 100 (n)	0.95	⇩	
	Mortality Reviews (Medical Examiner Screens)	Feb-18	100% (n)	85%*	⇩	
	Medical Examiner Scerens selected for Structured Judgement Review (SJR)	Feb-18	Expected rate is 10 - 20%	11%*	⇩	
	Total number of deaths of patients affected with a Learning Disability (automatically flagged for the LeDeR** review programme)	Feb-18	N/A	0	⇩	

Figures for mortality reviews (screens and selection for SJR) are as at the end of the month shown and may increase as deaths occurring late in the month are screened. Previous month's figures have been updated accordingly to show in the trend line.
LeDeR: Learning Disabilities Mortality Review Programme

Indicator		Date(s) of Latest Data	Standard / Target (n = national)	Latest Data	Change (from last data point)	Trend
Maternity and Neonatal	Term babies admitted to the neonatal unit	Feb-18	≤ 4% (n)	0.0%	⇩	
	Extended perinatal mortality rate***	Rolling year to Feb 18	≤ 5.61 per 1,000 (n)	4.65	⇩	
	Still born babies ≥ 24 weeks gestation	Rolling year to Feb 18	< 3.87 per 1,000 (n)	3.87	⇩	
	Neonatal death	Rolling year to Feb 18	< 1.74 per 1,000 (n)	0.77	⇩	
Complaints	Complaints (number received)	Feb-18	Not set	38	⇩	
	Complaint responses within 25 working days	Jan-18	≥ 85%	78%	⇩	
	Complaints open at 90 days within trust control	Feb-18	0	24	⇧	
	(Of these, number being investigated as serious incidents)			*(6)*		
	(Of these, number that are with the Ombudsman)			*(3)*		
Friends and Family Test (FFT)	Inpatients - response rate	Feb-18	≥30%	40%	⇧	
	Inpatients - recommended	Feb-18	≥ 95%	94%	⇩	
	Accident & Emergency - response rate	Feb-18	≥30%	8%	⇩	
	Accident & Emergency - recommended	Feb-18	≥ 95%	91%	⇧	
	Maternity - response rate	Feb-18	≥30%	27%	⇧	
	Maternity - recommended	Feb-18	≥ 95%	97%	⇔	
	Community - recommended	Feb-18	≥ 95%	97%	⇔	
	Outpatients - recommended	Feb-18	≥ 95%	94%	⇩	
Frailty (patients age >75 yrs; wards 8 & 9 + 1 & 2)	Patients with a frailty assessment completed	Jan-18	75.0%	57.5%	⇩	
	Patients with a frailty care plan completed	Jan-18	75.0%	50.0%	⇧	
Fractured Neck of Femur (#nof)	Time to theatre (within 36 hours)	Feb-18	90%	70.9%	⇩	
Cancelled Operations	Operations cancelled on the day for non-clinical reasons	Feb-18	< 114	64	⇩	
	Patient cancelled on the day offered a binding new date within 28 days	Jan-18	100%	100%	⇔	

Extended Perinatal Mortality Rate includes any stillbirth or neonatal death before 28 completed days after birth.

b) Care Quality Commission (CQC) Insight Report Indicators

The CQC publishes an Insight Report on providers which brings together and analyses the information the CQC holds about the provider's services. The table below shows indicator areas in the *Trust and Core Service Analysis* section which compares trust performance and national average (where applicable or available) and is set out in line with the Key Lines of Enquiry (KLOE). The report gives indicators a 'performance level' against a national average (if available/applicable) and 'performance change'

February 2018	Change			
KLOE - Comparison with National Average	Improving	About the Same	Declining	Not Applicable or Not Stated
Much Better	0	2	0	0
Better	3	5	0	1
About the Same	10	104	3	50
Worse	1	2	4	1
Much Worse	0	0	2	0
Not Applicable or Not Stated	5	11	1	6

Indicators showing 'better' or 'much better' for national comparison

Indicator	Latest Data for Trust		National Average
Sick days for medical and dental staff- [set target 3.5%]	Oct 16 – Sep 17	1.12%	1.13%
Sick days for non-clinical staff	Oct 16 – Sep 17	2.90%	4.17%
Staff experiencing harassment, bullying or abuse from staff	Sep – Dec 16	19.9%	Not given
Unplanned re-attendance to A&E within 7 days	Nov 17	5.3%	8%
Patients spending less than 4 hours in single specialty A&E	Dec 17	100%	99.4%
Overall team-centred rating score for key stroke unit indicator	Apr – Jul 17	Level B	Not given
Emergency readmissions: Pneumonia	Jul 16 – Jun 17	80	100
Crude percentage of patients documented as not developing a pressure ulcer	Jan – Dec 16	99.3%	95.6%
Cancelled operations not treated within 28 days of non-clinical cancellation	Jul – Sep 17	0%	6.8%
Emergency Laparotomy: Crude proportion of highest-risk cases (>10% predicted mortality) admitted to critical care post-operatively	Dec 15 – Nov 16	88.1%	86.6%
Patients waiting over 6 weeks for diagnostic test	Nov 17	0%	1.8%

Indicators showing 'worse' or 'much worse' for national comparison

Indicator	Latest Data for Trust		National Average
Patients spending less than 4 hours in any type of Accident and Emergency	Dec 2017	82.5%	83.1%
Patients spending less than 4 hours in major Accident and Emergency	Dec 2017	69.7%	77.3%
Emergency Laparotomy: Cases with access to theatres within clinically appropriate time frames	Dec 15 – Nov 16	74.8%	82.7%
Emergency Laparotomy: Cases with pre-operative documentation of risk of death	Dec 15 - Nov 16	41.6%	70.7%

Indicator	Latest Data for Trust		National Average
Emergency Laparotomy: High-risk cases (>5% predicted mortality) with consultant surgeon and anaesthetist present in theatre	Dec 15 - Nov 16	69.9%	79.2%
Patient Reported Outcome Measures (PROMs) - Groin Hernia Surgery	Apr 15 - Mar 16	Lower 95%	Not given
Hip Fracture - Crude overall hospital length of stay	Jan - Dec 16	26.2	21.6
Ratio of births to midwifery staff	Oct 16 – Sep 17	34.01	26.82
Stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births)	Jan - Dec 15	5.5	5.2
Full bed occupancy levels for neonatal intensive care beds	Sep – Nov 2017	2 months of full occupancy	Not given

Section 2: Further Information and Actions

a) Main Dashboard Indicators – Good Practice

i) Mortality Reviews

Positive themes from screening of the case notes and speaking with bereaved relatives/friends have included good documentation, good family discussions and good End of Life (EoL) discussions. The launch of medical examiner role has undergone frequent PDSA (plan, do, study, act) cycles to improve and streamline the process leading to quality improvements throughout. Additional resource was achieved to meet demand over the winter period.

The total number of cases selected for Structured Judgement Review (SJR) review remains in the expected range in line with Royal College of Physicians (RCP) recommendations. All learning disability deaths undergo SJR review which subsequently informs Learning Disabilities Mortality Review Programme (LeDer) regional review with multi-agencies.

b) Main Dashboard Indicators - Areas for Improvement or Review

i) Sepsis

The Consultant Nurse for Critical Care Outreach is supporting sepsis work alongside working on improvements to care of deteriorating patients overall. An updated Quality Improvement Plan (QIP) and audit programme is being agreed for 2018/19. Work will be based on the sepsis CQUIN[1], which focusses on timely identification and treatment for sepsis and a reduction of clinically inappropriate antibiotic prescription and consumption.

[1] *Commissioning for Quality and Innovation – schemes that are intended to deliver clinical quality improvements and drive transformational change*

ii) Hospital Acquired Thromboses (HATs)

The Venous Thromboembolism (VTE) group has been re-established and is chaired by the trust's VTE clinical lead. The group reports into the Quality and Safety Committee. The VTE policy has recently been updated and formally approved. Further work of the group is being agreed in a work plan with measures to help reduce risk of hospital acquired thromboses. The plan will be overseen at the group and updates provided for the Quality and Safety Committee. Success criteria for the group/plan will be meeting national requirements for VTE prevention and a reduction in the number of HATs.

iii) Pressure Ulcers

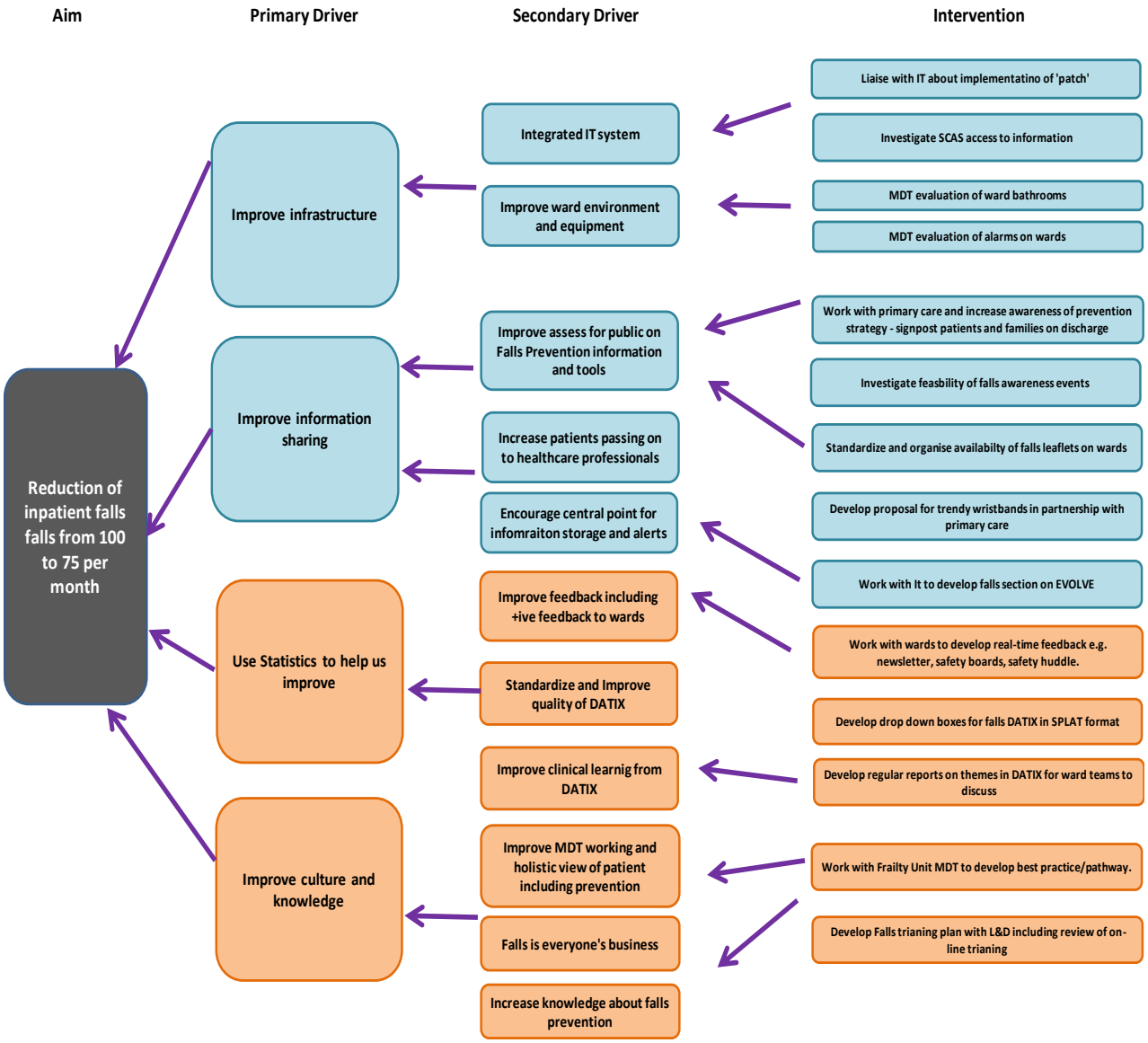
A pressure ulcer summit took place in February, with a cross-divisional and cross-professional approach. The outcome from the summit was a number of recommendations. These related to transfer and handover of a patient from one clinical area to another, review of paperwork and simplifying processes for ordering of equipment, resource and activities to support staff on tissue viability, training and guidelines and clinical governance activities.

The actions from these outcomes will be agreed and monitored at divisional level and, thus any exceptions reported via Quality and Safety Group.

iv) Falls Prevention

Falls prevention continues to be a key quality priority for the trust and action plans are in place to support a reduction in the number of patient falls. Following a recent 72hr report there is now a new emphasis on having doctors in the bay to support the 'stay in the bay' initiative.

A driver diagram (below) which will be used with the Falls Strategy Group to develop improvement work streams has been created with the support of the service improvement team and actions for implementation will be agreed and fed back through the quality and safety group.



v) Mortality Reviews

All Medical Examiner screens are fed back to the specialty Mortality and Morbidity (M&M) leads, ward sisters and matrons (especially where relative feedback has been received) and specialty nurses (e.g. sepsis) where the need for improvement has clearly been acknowledged. All reviews where the patient was subject to an agreed Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR), along with those relating to End of Life care are fed back to the palliative care team. The mortality review process and learning is overseen via the trust Mortality Reduction Group.

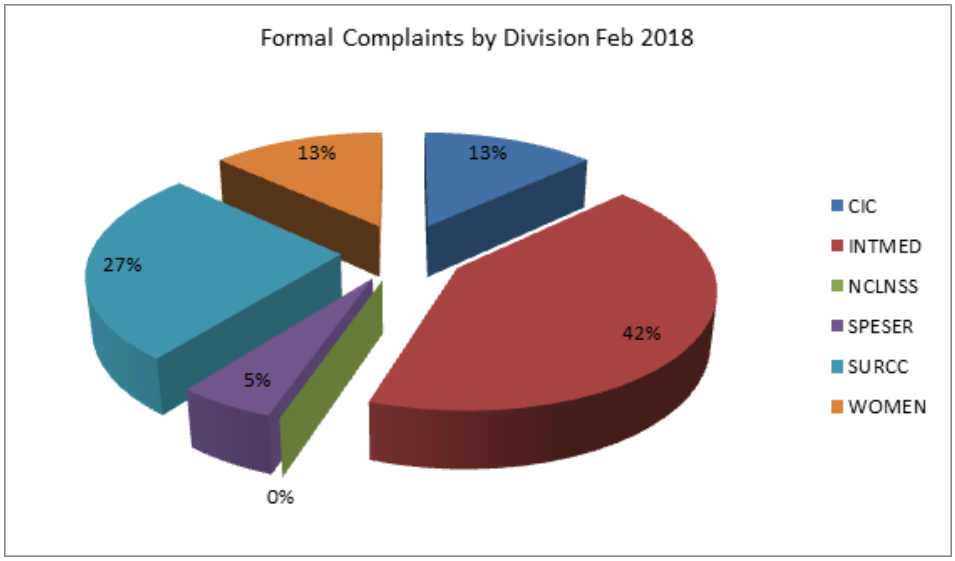
vi) Complaints and compliments

The Trust achieved a 78% speed of response for January cases responded to in February, which was principally due to breaches within integrated medicine. In addition to demands on

the service, January saw a higher than average number of new complaints (51 Trust wide) which will have impacted our ability to respond within target timeframes.

February, in a shorter month, brought 38 new formal complaints in-line with 34 received in February last year. The first three quarters of 2016/17 we received 376 new formal complaints and the first three of 2017/18 we received 388. Completion of March intake and full quarter 4 data will give us a better understanding of whether this indicates an upward trend.

It is also important to add that since April 2017 we have recorded over 9000 compliments received by wards and localities for the Trust.



CIC
Division of Integrated Elderly and Community Care

INTMED
Division of Integrated Medicine

NCLNSS
Corporate and Non-Clinical Support Services

SPESER
Division of Specialised Services

SURCC
Division of Surgery and Critical Care

WOMEN Division of Women, Children & Sexual Health Services

vii) Frailty Assessments

Focus for improvement is on the Trauma and Orthopaedic wards at Stoke Mandeville. The Care of Elderly People clinical team is leading on work to improve compliance, including work with medical trainees both in induction and during their placements.

viii) Patients with fractured neck of femur to theatre within 36 hours

The main reasons for patients waiting more than 36 hours are being medically unfit for surgery/anaesthetic, although some are due to administrative and logistic issues, such as overrunning theatre lists. An overall action plan is in place, overseen within the division of Surgery and Critical Care governance processes, which report into the trust Quality and Safety Committee for oversight.

c) CQC Insight Report Indicators

i) Emergency Laparotomy: Documentation of risk

The figure is a reflection of poor documentation rather than poor compliance. We have addressed this with the Boarding Card & the evidence of this should reflect in the 4th annual report.

ii) Hip Fracture: Hospital length of stay

Figures for this trust on the audit show total length of stay (LoS) for both the acute period and community hospital stay, reflecting that this is an integrated trust. The majority of trusts in the national data only have the acute section of care. Taking into account the acute care stage only, figures are comparable with the national mean.

- 2016 – acute LoS = 18.2 days
- 2017 – acute LoS = 16.3 days (overall LoS = 22.4 days)

iii) Stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births)

This indicator relates to 2014/15; extensive work was undertaken in the trust, including an external review. Up to date data can be seen on the current main dashboard and is within the current target range.

Report compiled by:	**Christine Skeldon, Head of Medical Quality and Development** **Jo Atkins, Associate Chief Nurse**
Date:	**21st March 2018**

Agenda item: 12
Enclosure no: TB2018/32

Safe & compassionate care, every time

Buckinghamshire Healthcare NHS Trust

PUBLIC BOARD MEETING
28 March 2018

Details of the Paper

Title	Infection Prevention & Control report
Responsible Director	Dr Tina Kenny
Purpose of the paper	To provide the Board with Infection Prevention data for February
Action / decision required (e.g., approve, support, endorse)	For information

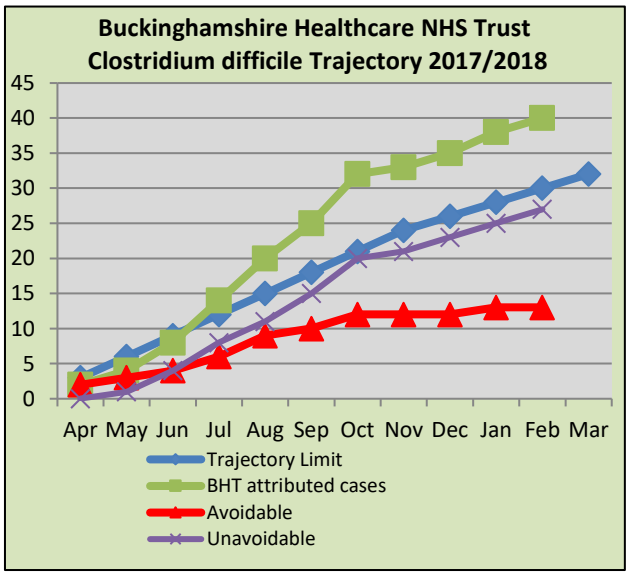
IMPLICATIONS AND ISSUES TO WHICH THE PAPER RELATES (PLEASE MARK IN BOLD)					
Patient Quality	*Financial Performance*	*Operational Performance*	*Strategy*	*Workforce performance*	*New or elevated risk*
Legal	*Regulatory/ Compliance*	*Public Engagement /Reputation*	*Equality & Diversity*	*Partnership Working*	*Information Technology / Property Services*

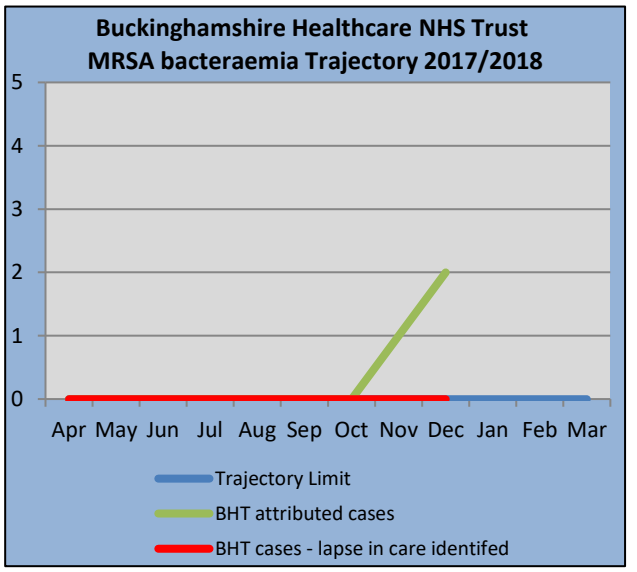
ANNUAL OBJECTIVE	
Which Strategic Objective/s does this paper link to? *Annual HCAI objectives* *MRSA bacteraemia: Zero cases 2017/18* *Clostridium Difficile: 32 cases 2017/18*	
Please summarise the potential benefit or value arising from this paper: The report outlines Healthcare Associated Infection data for February	
RISK	
Are there any specific risks associated with this paper? If so, please summarise here.	*Non-Financial Risk*:
	Financial Risk:
LINK TO CARE QUALITY COMMISSION ESSENTIAL STANDARDS OF SAFETY AND QUALITY	
Which CQC standard/s does this paper relate to?	15 (2) *(if you need advice on completing this box please contact the Director for Governance)*

Author of paper: Amanda Adkins
Presenter of Paper: Dr Tina Kenny
Other committees / groups where this paper / item has been considered: **Quality Committee and IPC committee**
Date of Paper:21/03/18

Infection Prevention & Control Report – February 2018

February 2018	Limits set by PHE	Trust Total from April 2017	Integrated Medicine	Integrated Elderly & Community Care	Women, Children & Sexual Health Service	Surgery & Critical Care	Specialist Services
Clostridium difficile	32	40	1	0	0	0	1
MRSA Bacteraemia	0	2	0	0	0	0	0
MSSA Bacteraemia (BHT associated (post 48 hours))	n/a	18	0	0	0	0	0
Gram-negative bacteraemias (E.Coli , Klebsiella & Pseudomonas aeruginosa) (BHT catheter associated)	n/a	1	0	0	0	0	0
Line Infections	n/a	31	0	0	0	0	0
Hand Hygiene Observational Audit Compliance %	n/a	n/a	99%	100%	99%	99%	99%





For 2017/2018 the Trust objectives are

Clostridium difficile 32 cases
MRSA bacteraemia 0 cases

MRSA Bacteraemia – One community case
CCG to arrange Post infection review meeting to discuss this case.

Clostridium difficile - *2* cases identified in February
Post infection reviews have been undertaken.

Learning from PIR for
- Case 1 - unavoidable case. No lapse in care
- Case 2 – unavoidable case. Delay in isolation

Meticillin Sensitive Staphylococcus aureus (MSSA) Bacteraemia – 0 cases identified in February.
Those that are BHT associated with devices will have a Root Cause Analysis (RCA) carried out.

Gram-negative bacteraemias (E.coli, Klebsiella & Pseudomonas aeruginosa) – the team will be carrying out a mini Route Cause Analysis on BHT acquired urinary catheter associated Gram negative bacterial blood stream infections (GNB BSIs) in real time when informed of these cases by the duty microbiologist dealing with these cases. As the national picture becomes clearer and if/when GNB BSI become mandatory, the trust and the CCG will review the most appropriate mechanism to be developed at that point.

0 cases identified in January.

Line Infections - 0 cases in February

Central lines: Benchmark - Zero tolerance to avoidable line infections

Agenda item: 13
Enclosure no: TB2018/33

Safe & compassionate care, every time

Buckinghamshire Healthcare NHS Trust

BOARD COMMITTEE SUMMARY REPORT FOR QUALITY COMMITTEE

Name of Committee	Quality Committee
Committee Chair	Professor Mary Lovegrove
Meeting date:	6th February 2018
Was the meeting quorate?	Yes
Any specific conflicts of interest?	None
Any apologies	Miss S Barber; Professor D Sines; Mrs J Ballinger; Mrs N Whittome

KEY AREAS OF DISCUSSION:

The Committee received assurance on the following:

Never Event – wrong lens placed into a patient following cataract surgery. Patient notified and the incident did not result in harm.

Review of Division of Integrated Elderly and Community Care –

- Diverse services offered by the Division
- Diversity of roles within the workforce
- Discharge to assess
- Use of the Community Information Responsibly, Circulate Learning Effectively (CIRCLE)
- Use of the Perfect Ward app
- Challenge around medicines management
- Concern around numbers of falls in December 17 and the actions being taken to address this
- Integrated community teams benchmark data
- Skill mix model developed at Marlow Community Hub

Quality metrics within the Floodlight Integrated performance report

Infection control update

AREAS OF RISK:

- Falls and pressure ulcers
- Medicines management

ANY EXAMPLES OF OUTSTANDING PRACTICE OR INNOVATION:

AUTHOR OF PAPER:	Liz Hollman, Director for Governance

Agenda item: 13
Enclosure no: TB2018/33

Name of Committee	Quality Committee
Committee Chair	Professor Mary Lovegrove
Meeting date:	6th March 2018
Was the meeting quorate?	Yes
Any specific conflicts of interest?	None
Any apologies	Mr Macdonald; Professor Sines; Mr Dardis; Mr Khaki; Mrs Brooke; Miss Tasker; Mrs O'Kelly; Mrs Ricketts; Mr Tabay.

KEY AREAS OF DISCUSSION:

The meeting took place on a day when the organisation was exceptionally busy operationally. It was therefore agreed to keep the agenda to a minimum and to release front-line clinical staff from attendance. The Chair expressed the appreciated on behalf of the Committee to everyone delivering care to patients. The Committee through the Medical Director also acknowledged the support offered by partners including the Clinical Commissioning Group, Social Care, and South Central Ambulance Service.

The Committee agreed to seek approval from the Board to change the name of the committee from Quality Committee to Quality and Governance Committee as this better reflects the work carried out by the Committee.

The Committee received assurance on the following:

Business planning – key focus on safety outcomes, hearing the patients' voice, building on work already started to ensure BHT is a learning organisation and introducing clinical accreditation to recognise staff excellence.

New Serious Incident process has been introduced to build on and strengthen the existing process, in particular the focus on learning from serious incidents.

The Committee Chair was keen to see the introduction of a Quality Framework that encompasses care of patients and staff and this will be linked to the review of the Quality Strategy in 18/19.

The full Quality report was presented and discussed and would be presented to the Board.

Infection prevention and control. Discussion focused on Antimicrobial stewardship, e-prescribing and the impact of the challenging capital budget.

The Committee reviewed assurance around the Annual review of compliance with legislation. The process for monitoring compliance had been strengthened through the year and a template for each piece of legislation/regulation was in the process of being completed by a management lead and signed off by an executive director. The majority of the elements had already been completed and those which were outstanding would be completed before the Board.

The Corporate Risk Register was reviewed.

The Quality Committee annual programme was supported.

AREAS OF RISK:

The limited capital budget has the potential to significantly impact on quality and safety given that medical equipment, Information Technology, and estates management are all dependent on this budget.

ANY EXAMPLES OF OUTSTANDING PRACTICE OR INNOVATION:

The staff commitment to delivering high quality care in a high pressure environment.

AUTHOR OF PAPER:	Liz Hollman, Director for Governance