

Board of Directors (in Public)

Item 6.1.3.1
Subject: BAF Key Issues Report – Quality committee
Date of Meeting: 29th October 2018
Prepared by: Sue Pemberton, Director of Nursing and Quality
Presented by: Sue Pemberton, Director of Nursing and Quality
Meeting Held: 6th November 2018
Purpose of Report: To Note

Agenda Item	Lead Exec	BAF RAG	Assurance Received	New/Emerging Risks	Actions/Comments
6.1	Dr Perry	Baf 1.1 3 x 3 = 9	Work is underway to improve door to balloon time and call to balloon time in Cath Labs. Main delays in call to balloon time are due to external factors e.g. ambulance timings, and delays in A and E units. Main reason for door to balloon time delays are when multiple PPCI Patients arrive at similar times.	No new risks	The Trust has shared the work we are doing working with the ambulance service to try to improve timely transfer of patients to Cath labs. Work is underway in the labs to look at activity across the week and to look at regular patterns of work and on call as due to increase in PPCI patients out of hours.

6.1	Dr Perry	Baf 1.1 3 x 3 = 9 Moderate/ possible	Recent mycobacterium chimera X 2 in the water coolers in theatres.	Escalation to the risk register was considered – the Quality Committee do not believe this is a risk currently.	Work led by NHS England has been implemented in the Trust inclusive of monthly sampling. Work is underway to review the total number of patients that may have been affected.
7.1	Dr Perry	Baf 1.4 3X2 = 6 moderate/ likely	Getting it right first time (GIRFT) report	None	An update on the work carried out to date following the receipt of the report was presented inclusive of an action plan completed by the surgical division. The committee felt that more detail was required in relation to the incidence of stroke and returns to theatre. They also felt that the action plan required strengthening with clear time frames where possible for delivery. It was suggested that the AMD for surgery attend the next meeting together with the stroke consultant and head of physiotherapy to review the stroke related elements within GIRFT.
7.2	Dr Jackson	Baf 1.4 2 x 4 = 8 Minor/ likely	Mortality alerts	None	The paper had previously been reviewed at the Board of Directors. The committee discussed the mortality strategy for improvement. The committee was assured that appropriate actions are in place.

9.1	Dr Perry	Baf 1.1 3 x 3 = 9	Serious Incident Report	None	The final report was reviewed and the learning discussed in relation to the recent serious incident where a patient was discharged with a higher dose of gabapentin than was prescribed. There was learning in pharmacy around the dispensing of the medication and learning regarding the discharge process.
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