TRUST BOARD

Title:	**Key Issues and Escalation Points**
Name of Committee:	**Quality Improvement & Safety Committee**
Committee Chair:	**Dr Anne Mcconville**
Meeting Date:	**12 December 2018**

Summary of key messages:

The following annual reports for 2017 / 2018 were presented and discussed:

- Infection Prevention & Control (IPaC) - the main focus was on clinical environments and estates based IPaC activity and risks.

- Research – the significant increase in participation in research studies was outlined along with the positive effects of our Research team working to encourage teams to participate in a wide range of research activity from poster presentations through to participation in national studies.

The Q2 Learning from Deaths report was received, discussed and is attached as an appendix to the Quality report to the Board.

There was a discussion re safety culture and all services will be asked to incorporate actions relating to improving our safety culture in their 2019 / 2020 annual service plans (Quality performance section). This is outlined in Priority 1 of the current Quality strategy.

A summary of trends relating to pressure ulcers was presented by the Deputy Chief Nurse and the continued work to improve care for patients in this area noted..

Escalation Points:

One Serious Incident was reported in October relating to failure to escalate safeguarding concerns.

The 2018 Never Event list was updated to include Implantation of a wrong intrauterine contraceptive device. One such incident was reported in November from our iCaSH service in Suffolk. A summary is included in the Quality report.

Both of these incidents are currently under investigation.

The bi- annual review of all Quality related risks was undertaken – two risks rated 16:

- Single Point of Access for Bedfordshire 0 - 19 Service.
- Safeguarding Team (Cambridgeshire)

These risks are reported and managed through the relevant Clinical Operational Boards where mitigating actions are outlined and assessed.

There are no actions required from the board at this point.

Emerging Risks/Issues:
A second Never Event relating to implantation of the wrong intrauterine device was reported in November from iCaSH Peterborough. This is being investigated alongside the first incident noted above to ensure that appropriate learning is identified.

Examples of Outstanding Practice or Innovation:
Research activity outlined in key messages.

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