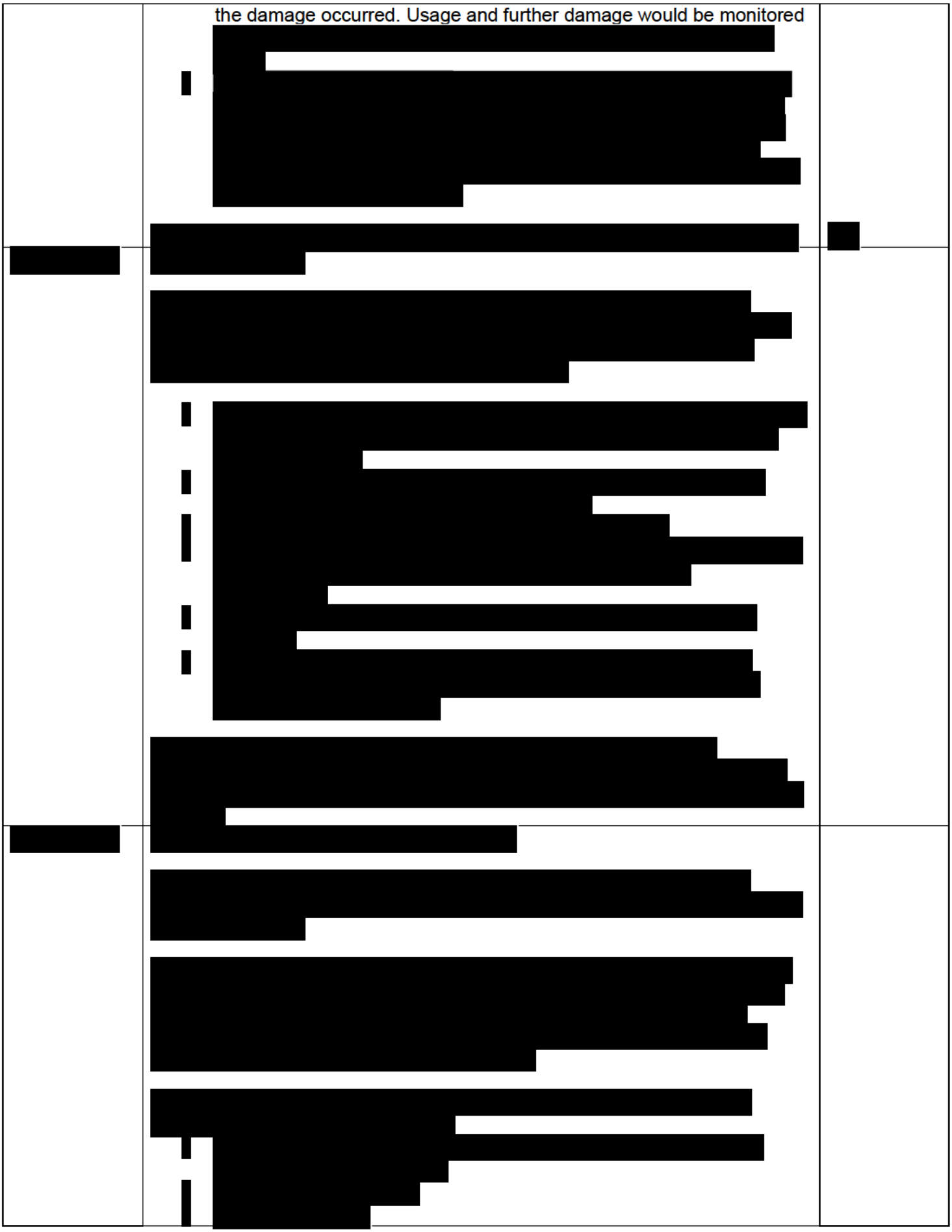
Kent & Medway NHS & Social Care Partnership Trust - Quality Committee (QC)

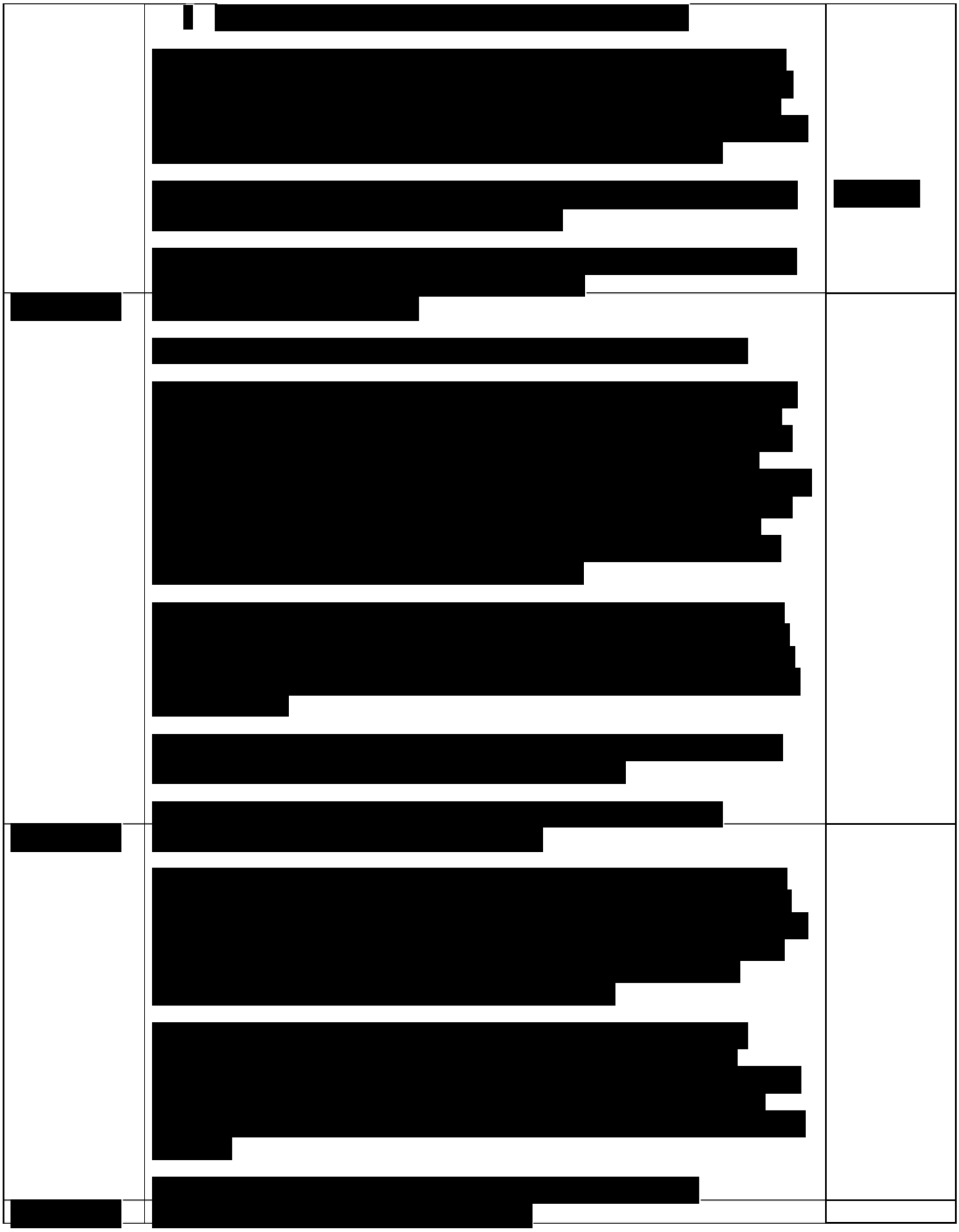
Minutes of the Meeting held at 13:00 – 16:00, Tuesday, 17 September 2019 in Boardroom A, Farm Villa, Hermitage Lane, Maidstone, Kent, ME16 9PH

Members	
[redacted]	Non-Executive Director (Chair)
[redacted]	Non-Executive Director
[redacted]	Executive Director of Nursing and Quality
[redacted]	Executive Medical Director
[redacted]	Deputy Chief Operating Officer for JMG
[redacted]	Trust Professional Lead for Allied Health Professions
[redacted]	Deputy Director of Quality and Safety
[redacted]	Chief Pharmacist
In attendance	
[redacted]	Consultant Psychiatrist (item QC/19-20/75 only)
[redacted]	Team Leader Canterbury (pilot site) (Memory Services) (item QC/19-20/75 only)
[redacted]	Team Leader – DGS (pilot site) (Memory Services) (item QC/19-20/75 only)
[redacted]	Interim Trust Secretary
[redacted]	Deputy Director of Nursing Practice (observing)
[redacted]	Minutes
Apologies	
[redacted]	Non-Executive Director (Vice-Chair)
[redacted]	Chief Operating Officer (COO)
[redacted]	Head of Risk
[redacted]	Head of Psychological Therapies

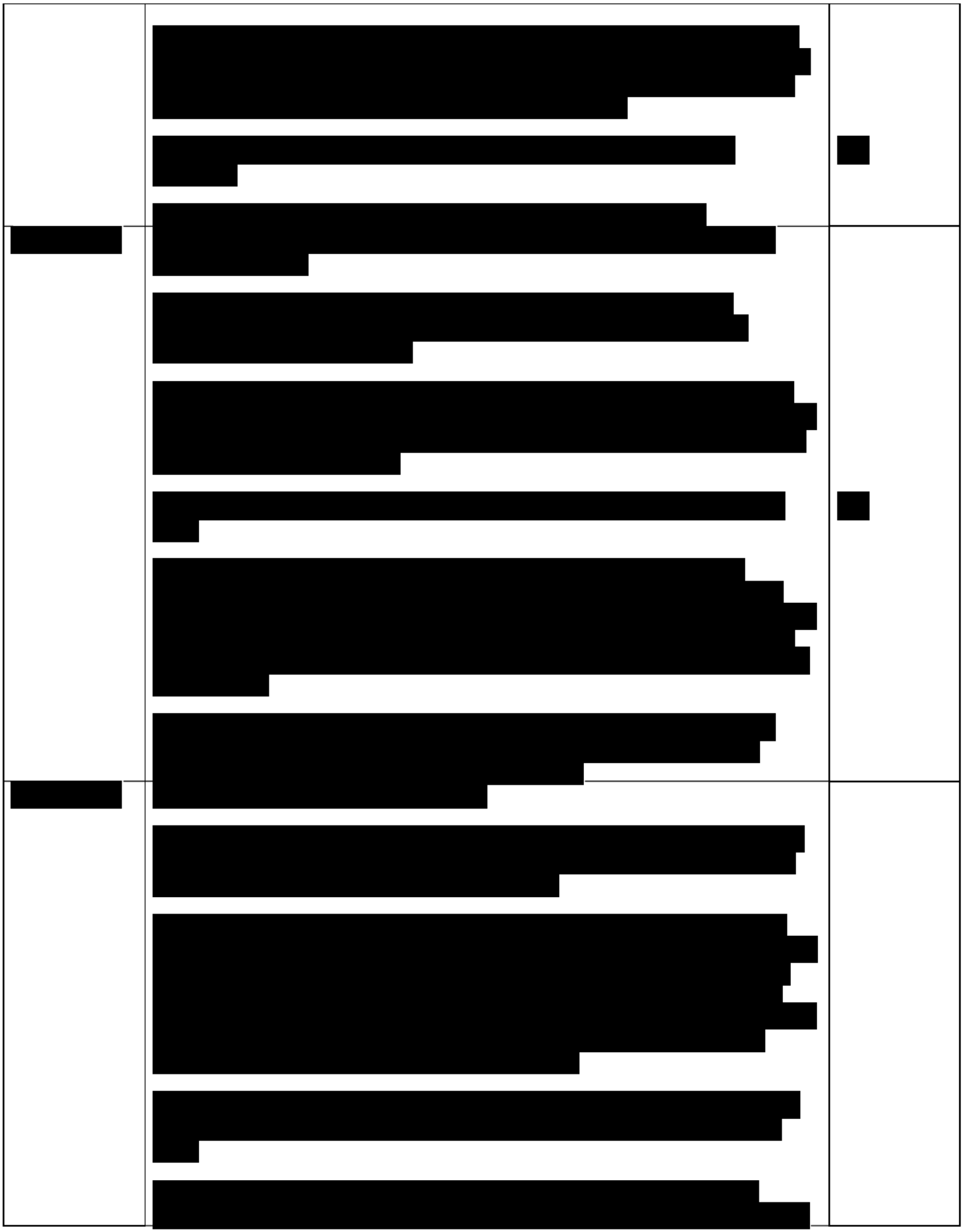
Item		Who
[redacted]	[redacted]	
[redacted]	[redacted]	
[redacted]	[redacted]	
[redacted]	[redacted]	

the damage occurred. Usage and further damage would be monitored





	[redacted]	
QC/19-20/81	**Report on new approach to the actions arising from Serious Incidents and how they are produced and implemented** The context to the report was the previous use of DATIX, which did not allow themes to be identified and robustness of scrutiny of actions to complete and close plans. DATIX was now capable of being used to identify themes and Trust and Care Group processes were in place to evidence the action taken to enable action plan closure. Committee members remained concerned about the number of actions generated from SI investigations and asked when reduced numbers could be expected. A new Patient Safety Framework had recently been issued and in order to take into account the revised guidance, it will be March 2020 before a more systemic approach can be embedded. In the interim it was agreed that HS will oversee the review of outstanding actions of more than one year, with the aim of either streamlining or closing them, as appropriate. This will be reported to the TWPSMRG. **Action: [redacted] to revisit oldest action plans and consider closure depending on whether any related inquest or safeguarding review had concluded. TWPSMRG would oversee the further review of outstanding actions, in order to ensure that all recommendations are SMART** The Committee raised the issue of embedding learning and how this could be tested. It was suggested that the best marker was reduction in SI's and increase in reporting of no harm incidents. Assurance was sought that learning was embedded across teams. This was confirmed but more work on learning between Care Groups was being progressed. The Committee **RECEIVED** and **NOTED** the Report on new approach to the actions arising from Serious Incidents and how they are produced and implemented.	[redacted]
[redacted]	[redacted]	



	[redacted]	

Signed ..... (Chair)

Date .....