Paper 5.0

# BCCG Governing Body Action Tracker 2018

NHS Bedfordshire Clinical Commissioning Group

| Meeting Date/ Ref Number | Action | Update | Nominated Lead | Target completion Date | Completion Date |
|---|---|---|---|---|---|
| 5.7.18 | **Integrated Quality, Safety and Performance Report**<br><br>Still birth rates were above the national average and a full audit was being undertaken. This is discussed at the Quality Contract Meetings and one of the key priorities of the local maternity service Strategic Board is to reduce the rates of still births. **Action: AM to provide an update report to the GB.** | BHT have undertaken a thematic review of all stillbirths covering the period Jan 2017 – Dec 2017. With a live birth rate number of 2864 births this leads to a BHT still birth rate of 5.24%. Recognising that this is still higher than the national average of 4.6% for stillbirths this data includes terminations of pregnancies that were delivered after 24 weeks gestation (as these are after 24 weeks they are still recorded in the reporting for stillbirths). Following review the Trust have developed an action plan for key areas of improvement. | **Anne Murray** | **September 2018** | **Propose to close** |
| 5.7.18 | **Integrated Quality, Safety and Performance Report**<br><br>There has been a spike in never events at Bedford Hospital. The CCG is seeking assurance that all is being done, such as WHO check list, **Action: AM to update the GB on the assurance** | Meetings held with BHT theatre and Clinical Governance teams. Thematic review report receive and presented in relation to the Never events reported over a 1 year period. No themes were seen in relation to specific teams or times that incidents took place. | **Anne Murray** | **September 2018** | **Propose to close** |

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| | | Detailed actions agreed which include Human Factor training for all staff, Theatre safety group and audit programme of WHO check list.<br>Good assurance received,<br>2 day CQC visit also undertaken within Theatre setting with no immediate actions.<br>Full report awaited. | | | |
| 5.7.18 | **Integrated Quality, Safety and Performance Report**<br><br>A CQC report on ELFT declared them as "outstanding". Although there have been concerns over the number of self-harm incidents. AB asked what assurance the GB could have that the CCG was keeping a close eye on this. AM said the process was under constant review in the regular Quality Contract Meetings. **Action: AM to provide an update at the next GB meeting** | BCCG quality team have undertaken a detailed review of the number of unexpected deaths of ELFT service users in the last 18months. This details of this report was shared in a meeting with ELFT Chief medical Director and Chief Nurse in a meeting on ELFT serious Incidents.<br>ELFT have also commissioned an internally led report to look at lessons learned and potential for improvement. In addition they have a detailed Quality Improvement project to look at improvements in service delivery with engagements with CCG and public health. | **Anne Murray** | **September 2018** | **Propose to close** |