CCG(M) 22/01
Minutes 01 - 13

NHS GREATER GLASGOW AND CLYDE

Minutes of the Meeting of the Clinical and Care Governance Committee held on Tuesday 1 March 2022 at 2.00 pm via Microsoft Teams

PRESENT

Ms Susan Brimelow OBE (in the Chair)

Mr Ian Ritchie (Vice Chair)	Mr David Gould
Dr Lesley Rousselet	Dr Paul Ryan
Ms Paula Speirs	Cllr Caroline Bamforth

IN ATTENDANCE

Ms Jane Grant	..	Chief Executive
Dr Jennifer Armstrong	..	Medical Director
Dr Scott Davidson	..	Deputy Medical Director – Acute Services
Ms Jennifer Rodgers	..	Deputy Nurse Director – Corporate and Community
Ms Sandra Devine	..	Acting Infection Prevention and Control Manager
Mr Andrew Gibson	..	Chief Risk Officer
Ms Geraldine Jordan	..	Director of Clinical and Care Governance
Ms Gillian Duncan	..	Secretariat
Ms Amy White	..	Secretariat (Minute)

			ACTION BY
01.	**APOLOGIES AND OPENING REMARKS**		
	Ms Susan Brimelow welcomed those present to the meeting of the Clinical and Care Governance Committee via video conferencing. Apologies for absence were intimated on behalf of Professor Iain McInnes, Dr Margaret McGuire and Ms Angela O'Neill. The Chair welcomed Ms Jennifer Rodgers, Deputy Nurse Director for Corporate and Community and Mr David Gould, Non-Executive Board Member. **NOTED**		

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02.	**DECLARATIONS OF INTEREST**		
	The Chair invited Committee members to declare any interests in any of the items to be discussed. No declarations were made. **NOTED**		
03.	**MINUTES OF MEETING HELD ON 14 DECEMBER 2021**		
	The Committee considered the minute of the meeting held on 14 December 2021 [Paper No. CCG(M)21/03] and were content to approve the minute as a full and accurate record of the meeting. **APPROVED**		
04.	**MATTERS ARISING FROM THE MINUTES**		
a)	**Rolling Action List** The Committee reviewed the items detailed on the Rolling Action List [Paper No. 22/01]. The Committee were content to close three items noted on the Rolling Action List. Ms Rodgers advised the Bi-Annual report from the Public Protection Forum would be presented at the next meeting scheduled June 2022. Ms Jordan reported she had a meeting with the Secretariat team to review the annual cycle of business to create a work plan for the papers that were deferred as a result of the governance light approach. Work remained ongoing to develop a proposal for the year ahead and it would be shared with the Chair and Vice Chair upon completion. There were no further matters arising that were not on the agenda. Secretary to update the list. **NOTED**		**Ms Jordan/ Secretary** **Secretary**

			ACTION BY
05.	**OVERVIEW**		
	Dr Jennifer Armstrong, Medical Director and Ms Jennifer Rodgers, Deputy Nurse Director for Corporate and Community provided an overview of the key priorities not included on the agenda to raise awareness; Dr Armstrong reported NHS Tayside had experienced a number of staff challenges with Consultants leaving the organisation over a short period of time. In January 2022, NHSGGC alongside NHS Lothian and NHS Grampian, were providing support to breast cancer patients from Tayside to access timely radiotherapy. The clinical advice was that these patients should be treated in Glasgow because of the different Algorithms and to translate radiotherapy planning in different machines would have created greater patient risk. NHSGGC agreed to the treatment of 3-4 patients a week however 7 patients a week had been treated to ensure any patients waiting accessed radiotherapy. Additional clinics were introduced for those patients traveling to Glasgow where they will discuss the radiotherapy plan with clinicians at the Beatson with treatment delivered at the Beatson. The patients can then return to Dundee for follow-up. Dr Armstrong advised a clear governance pathway would be established around those patients. Ms Rodgers reported a fatal accident enquiry would commence in the coming months with a Glasgow City child protection case where a child aged 2 years sadly passed in 2015 with severe neglect. The child presented with extreme neglect and two older siblings showed signs of neglect. There had been immediate improvement and actions taken, work was completed with Glasgow HSCP across health and social care in terms of an integrated plan with actions. The key points around the case were that the universal health visiting pathway had not been introduced and there was no standardised approach to children being visited by health visitors at that time. Since then it had been introduced and there was now a standardised pathway for all children under 5 years. There was immediate work on the health plan indicators, following the incident all children in GGC were reassessed in terms of the grading including context of their family and siblings. Work was completed to ensure robust communication and documentation of joint visits of school nurses and health visitors. Ms Brimelow thanked Dr Armstrong and Ms Rodgers for their updates and reassurance of the work ongoing in these areas. **NOTED**		

			ACTION BY
06.	**a) ACUTE SERVICES UPDATE**		
	The Committee considered the paper 'Acute Services Clinical Governance Report' [Paper No. 22/02] presented by Dr Scott Davidson, Deputy Medical Director – Acute Services. Dr Davidson advised the report provided an overview of clinical governance within Acute Services in NHSGGC. It highlighted the background to clinical governance arrangements within the Acute Services Division, the function of the Acute Services Division Clinical Governance Forum (ASD CG Forum), the arrangements to support the ASD CG Forum, ongoing monitoring and assurance arrangements for key quality indicators and the Board reporting/ oversight which notes challenges affecting the Division. Dr Davidson reported the past two years had been incredibly challenging with the pandemic and ASD CG Forum maintained monthly meetings, with a shorter 1 hour meeting focused on sector/ directorate updates and key service issues. The group maintains an annual reporting cycle, outlining routine reports to be presented to the group for information and assurance. Dr Davison confirmed the reports were wide and comprehensive which created discussion and debate. Each month the aim was to have a consistent number of reports to ensure enough time for each item. Dr Davidson highlighted the work completed by NHSGGC Thrombosis Committee and the National Patient Safety Alert when a small cohort of patients with mechanical heart valves were identified as being inappropriately switched from warfarin to a Direct Oral Anticoagulant (DOAC) during the pandemic. NHSGGC pharmacy and thrombosis colleagues worked timeously and thoroughly to look at every patient and positively concluded no patients within GGC were inadvertently switched. The ASD CG Forum routinely receive an update report from the clinical governance lead for each sector and directorate at every meeting. The report includes identification of up to 3 issues for discussion/ escalation to encourage debate. The work plan and priorities focus on the core objectives of safe care, effective care, person centred care and assurance. The key quality indicators for monitoring and assurance include the Scottish National Audit Programme (SNAP). Dr Davidson noted appreciation to the Clinical Governance Support Unit for their efforts collating information providing a thorough update to allow a continued focus on local improvement targets. Clyde Hospital Standardised Mortality rates (HSMR) remains above the		

			ACTION BY
	Scottish average, focused work on this had been re-established and a formal update from Clyde would be provided to Acute Services Division CG Forum in March 2022. Dr Davidson noted oversight of audit and governance processes within of the West of Scotland Cancer Audit Network (WoSCAN) Cancer QPI and ASD CG Form reporting to the Board CG Forum. Dr Davidson reported the key issues for escalation remain similar from throughout the year with unscheduled care and staffing. Despite the challenges with staffing there had been successes with the recruitment of Newly Qualified Nurses (NQNs) beginning to take up post which had been positive. The key risks identified included the waiting list for endoscopy; the recovery plan which varies alongside the wave of the pandemic; and challenges with Systemic anti-cancer therapy (SACT). Dr Davidson noted in conclusion the ASD CG Forum had robust clinical governance arrangements in place, maintaining a monthly meeting to contribute to the clinical governance agenda and monitor the quality of clinical care, as well as providing pathways to provide support and strategic oversight. There was a question regarding the process of sharing key risks and learning between Acute, Primary Care and Mental Health services. Ms Jordan noted learning summaries were shared on a clinical risk bulletin and there were many opportunities to share learning and work collaboratively with colleagues across Primary Care, Mental Health and Acute Services. There was a question in relation to action logs and risk registers and if that was solely for Acute services or if they were in place for Primary Care, Community and Mental Health services and would it be repeated across governance arrangements to ensure consistency of approach. Ms Armstrong advised there was a risk register for Acute and Corporate risks and a work programme for primary care to review risk. Ms Jordan advised the Chief Risk Officer had completed focus work on corporate risks. The identification of clinical risks within Acute is part of the standard business of the Acute Clinical Governance Forum and was an opportunity to capture and share learning. Ms Jordan advised that the divisional clinical governance forums maintain an action log and progress discussed at each meeting. Ms Jordan would follow up with the divisional Chairs to ascertain if they maintain a risk register for their individual clinical governance forums.		

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	Ms Brimelow thanked Dr Davidson for the comprehensive report regarding Acute Services Clinical Governance. The Committee welcomed the report and were assured by the information provided. **NOTED**		
	b) FLOW NAVIGATION CENTRE		
	The Committee considered the paper 'Quality of Care Review: Acute Flow Navigation Centre' [Paper No. 22/03] presented by Dr Scott Davidson, Deputy Medical Director – Acute Services. Dr Davidson advised the new service was introduced in December 2020, which was a virtual front door into the Acute Services within NHSGGC. The report included information and data for the agreed time period of December 2020 to August 2021; Clinical governance arrangements and the oversight of clinical quality; Safe Care; Effective Care and Person Centred Care. The Redesign of Urgent Care would see patients being advised to contact NHS24 with an urgent care issue. If following consultation with NHS24 the patient required further input at a Health Board level this call would be passed to the Flow Navigation Centre (FNC) or the Mental Health Assessment Units (MHAU) for a virtual clinical conversation. The redesign was intended to offer an alternative route for patients to access acute and mental health advice and was largely aimed at those patients who would have self-presented to an urgent care service with the objective of converting unplanned demand to urgent planned care. The FNC was hosted within the South sector, and reports into the South Sector Clinical Governance Committee. The General Manager for the service also attends the South sector management team meetings. Dr Davidson noted from the introduction of the FNC, 7 patient-related incidents were reported during the review period. All 7 patient-related incidents describe situations where another service would have been more appropriate. There were no potential SAERs reported during the review period therefore none met the threshold for organisational duty of candour.		

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	During the review period the service participated in the national redesign of urgent care patient experience project, carried out by the Scottish Government. Of the initial sample of 105, 51 patients, their carers or family participated in a follow up telephone questionnaire to understand their experience of the pathway, with the following themes identified in order of most common; efficient pathway; effective care and good communication from professionals in the pathway. Dr Davidson advised the FNC was an advanced practitioner service with input from senior decision makers. There was a weekly meeting with lead ANPs, fortnightly Safe Space meetings with NHS24 and the Scottish Ambulance Service (SAS) and a monthly lead AHP meeting, which included a standard agenda covering Datix, Complaints, Risk Assessments, Health and Safety, Staff Governance and E-learning. Dr Davidson noted in summary it was an early development with the hope to increase activity through the FNC at pace and there were regular service delivery meetings regarding that. There were processes and governance in place for monitoring and reviewing any issues for escalation and share keys successes/ learning across the Acute Division. There was a question in relation to the noticeable impact on ED services and why there was such wide variation in the length of time from the completion of triage at NHS 24 to the end of treatment for patients not admitted, with a range from 29 minutes to over 20 hours. Dr Davidson advised approximately 30% of patients had their care episode closed by FNC and don't require further medical input. At present that was around 10 patients not presenting to front door services which required greater numbers going forward. Dr Davidson advised the FNC was originally set up around minor injuries, where some patients were required to attend minor injuries the next day which had impacted on the long wait. MSK pathways and minor head injuries pathways had been introduced and more medical pathways were now being considered based on data for high volume conditions. There was a question in relation to staff delivering the service and if they were comfortable and confident as being the new point of contact. Dr Davidson confirmed there were currently no challenges experienced as the senior ANPs were confident in minor injuries which built up their confidence virtually. NHSGGC had adopted video conferencing more than telephone in comparison to other Health Boards which was positive to have eye to eye contact.		

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	There was a question regarding the data of the demographic of patients using the service and how would the success of the service be judged long term when it was completely rolled out from a strategic perspective. Dr Davidson advised the data on the patient demographic would be analysed highlighting elderly patients did use video conferencing and there was a choice to have a telephone call if preferred. Dr Davidson advised when judging success it would be hoped that no patient would present at ED without having went through the FNC, essentially changing the front door to the virtual front door. There was a further question regarding data and if it was collected from the location of the patient particularly in relation to those who reside near an ED and if they had started to use the FNC. Dr Davidson noted the data would be available and agreed it would be helpful to consider and analyse over a period of time to identify any trends. Members had asked the question on how long it would take for the public within GGC to use the service. Dr Davidson agreed it would take time as it was a significant culture change. There was a need for an ongoing external campaign and the Communications team were involved in redirecting and signposting. Ms Brimelow thanked Dr Davidson for the Acute Flow Navigation Centre Report. The Committee were assured by the robustness of the processes and governance outlined in the report. The Committee were content to note the report. **NOTED**		
07.	**CARE HOME COLLABORATIVE**		
	The Committee considered the paper 'Care Home Collaborative - Governance and Assurance' [Paper No. 22/04] presented by Ms Jennifer Rodgers, Deputy Nurse Director for Corporate and Community. Ms Rodgers reported following the first wave of COVID-19 in May 2020 Board Nurse Directors across Scotland became responsible for the provision of nursing leadership, support, and guidance within the Care Home sector. The Care Home Assurance Tool (CHAT) visits commenced across all NHSGGC partnerships in May 2020 in response to the impact of COVID-19. The visits provided additional specific infection control, nursing support and guidance to care homes in the provision of high quality personalised care for residents. This work was aligned to the Executive Nurse Directors responsibilities set out by Scottish		

			ACTION BY
	Government to provide nursing leadership, professional oversight, implementation of infection prevention and control measures, use of PPE and quality of care within care homes. Ms Rodgers advised the visits were 6 monthly or by exception more frequently and other visits would also continue to the 187 care homes. Keys areas of good practice identified on the visits were improvements in social distancing, outbreak management, communication and education, management of falls and management of indwelling devices. Areas that required to be strengthened include areas of Food Fluid and Nutrition and Tissue Viability. Ms Rodgers provided assurance that there were plans and work streams in place for those areas using intelligence from the visits and other governance processes. The visits were established however there was a requirement to consider a strategic longer term support mechanism for care homes and therefore the Care Home Collaborative (CHC) was developed. The CHC was a collaboration between all 6 HSCPs and was multi-disciplinary and multiagency including representation from the Care Home Managers, HSCP representatives, Scottish Care and Care Inspectorate. Ms Rodgers highlighted the success was the collaboration and effort to improve together with the overall shared purpose of enabling residents to live their best possible lives. Ms Rodgers noted the governance structures and highlighted HSCPs were at local oversight meetings where they rigorously review all the care homes within their area. Each care home was classified using the Director of Public Health (DPH) agreed RAG ratings; Red, Amber, Green. All homes identified as Red by exception would be included into a weekly report shared with the SG. Work would be completed locally with the HSCP team and the collaborative team for specialist support. The action plans would be held by the care homes who had ownership and the Care Inspectorate would be notified of any significant ongoing issue with any Red homes. Ms Rodgers advised there was a Care Home Governance and Assurance Group that was an oversight group for all 6 HSCPs which also had a sub-group to look into assurance such as the DPH report and the action plans associated with it. The Care Home Collaborative Steering Group was set up around the intelligence of the other groups to look at the focus work of improvement. The 5 core work streams identified and agreed were Infection prevention Control, Food Fluid and Nutrition, Person Centred Care, Right Care Right Place and Tissue Viability. The Care Home Collaborative Steering Group reports into Board Nurse		

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	Director Care Home Oversight Group which sets the strategy around the collaborative and how it progresses. Ms Rodgers noted in conclusion there had been a great deal of work completed around care homes which had robust leadership and rigorous professional and care governance. There was positive progress and early results thus far and currently in the process of recruiting key colleagues to the team. There was a question raised in relation to nurse director's having the responsibility of care homes however the Chief Officer's being accountable. Ms Rodgers agreed Chief Officer's remain accountable as there were no changes to their responsibilities including Chief Social Workers which was the reasoning behind the working together approach to be clear of each individual role with professional oversight to ensure a smooth process. There was a question regarding funding and if the funding allocation aligned to each Health Board to support Board Nurse Directors had been extended beyond March 2022. Ms Rodgers confirmed there was communication advising of the extension and noted of the consultation around the National Care Service which remained ongoing. There was a question on the analysed data and how it would be used to take a strategic approach to resolve any potential challenges. Ms Rodgers agreed the data was used for improvement using a quality improvement approach. There were driver diagrams for each of the 5 work streams which were driven from the data set to keep the group focused on outcomes and evaluation. Ms Brimelow thanked Ms Rodgers for the comprehensive report regarding the Care Home Collaborative. The Committee welcomed the report and were assured by the framework, governance processes and the positive early results. **NOTED**		
08.	**HEALTHCARE ASSOCIATED INFECTION**		
	Healthcare Associated Infection Reporting Template (HAIRT) The Committee considered the paper 'Healthcare Associated Infection Reporting Template' [Paper No. 22/05] presented by Ms Sandra Devine, Acting Infection Prevention and Control Manager.		

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	Ms Devine presented the HAIRTs for September and October 2021 and November and December 2021 and asked the Committee to note the Annual Operating Plan (AOP) targets set for 2019-2022 for Staphylococcus aureus bacteraemias (SAB), Clostridioides difficile infections (CDI) and E. coli bacteraemias (ECB). Ms Devine highlighted two incidents were reported at GRI Ward 64 within September and October 2021. There were 8 patient cases with Enterococcus faecium (VRE) reported within a 62 day period with first case testing positive on 24th July 2021 and the last case on 24th September 2021. VRE was an infection with bacteria that was resistant to some antibiotics therefore regularly monitored. Around the same time, there were two patient cases with Clostridioides difficile reported within a 4 day period. First case testing positive on 9th September and the last one on 12th September. As both incidents overlapped and were associated with transmission via contact, ARHAI advised to investigate both incidents together. VRE analysis identified no epidemiological links and both CDI positive patients were in bed spaces adjacent to each other in a 6 bed bay for 7 days. PCR ribotyping for both patients was 020 which indicated a cross transmission event. Ms Devine highlighted the challenges identified with near patient equipment as a consequence of nursing staffing levels and prioritising direct patient care resulted in patient equipment not always being clean and ready for re-use. Improvement was noted when an agency worker was employed to support nursing staff with decontamination of near patient equipment. Work was completed on hand hygiene and antimicrobial prescribing, debrief document was sent to the IPC Governance Committees for assurance and shared learning. Ms Devine noted the November and December 2021 report and advised the AOP targets continued to be a challenge, however they remain within the confidence intervals published within the ARHAI report. Quarter 3 ARHAI was included within the report for assurance which details NHSGGC performance in relation to NHS Scotland and demonstrates that NHSGGC was not an outlier in any category, however would continue to try and achieve the targets by continually improving and supporting changing practice to ensure the safety of patients. Ms Devine reported CDI rates remained within normal control limits for the period of the November and December 2021 report. It was noted that there was an increase in numbers in Glasgow Royal Infirmary during December when compared to their usual		

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	background rate. A multidisciplinary team including local clinicians, antimicrobial pharmacists and IPCT met to review all the cases and had suggested a number of actions which were currently underway. Progress on this review would be included in subsequent reports. The second issue of the Infection Prevention and Control Quality Improvement Network (IPCQIN) newsletter was issued to staff via Core Brief in February 2022. This would ensure shared learning across the organisation on the improvements implemented thus far by the network. The IPC Dashboard on Micro-strategy was now continually updated and frontline staff now had access to real time data on CDI, SAB, ECB and surgical site infections. Ms Devine advised COVID-19 activity continued to be a challenge with 356 in-patients and 21 wards closed. The rate of definite hospital onset for NHSGGC using national data up to 6th February 2022 was 0.6% and NHS Scotland was 0.5%. The SSI Surveillance was paused during December 2021 and January 2022 to allow surveillance nurses to work within vaccination centres and it recommenced on the 1st February 2022. There was a question regarding who was involved in setting the targets for the Annual Operational Plan (AOP) which was due to expire March 2022 noting the unlikelihood GGC would not meet them. Ms Devine confirmed the SG set the targets and ARHAI had created their own Dashboard awaiting on SG notification of the targets post March 2022. Ms Devine noted there was acceptance that this was an unusual time and SG would have to review the targets accordingly. Ms Grant advised NHSGGC were in the process of RMP5 and the AOP had been overtaken by the remobilisation plans. Discussions remain ongoing with SG on what should be included and would be incorporated into the remobilisation plan. Ms Brimelow thanked Ms Devine for the comprehensive reports regarding Healthcare Associated Infection Reporting Template. The Committee welcomed the report and were assured by the information provided. **NOTED**		

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09.	**EXTRACT FROM CORPORATE RISK REGISTER**		
	The Committee considered the paper 'Corporate Risk Register' [Paper 22/06] presented by Mr Andrew Gibson, Chief Risk Officer. Mr Gibson advised the paper noted the 4 risks aligned to Clinical and Care Governance Committee. The 4 risks identified on the register were; Infection Prevention and Control; Clinical Standards; Public Protection; Feedback & Person Centred Care. Following the recommendations at the Audit and Risk Committee on December 2021, there had been an expansion of the Risk Descriptors to make the risk and its potential impacts clearer. Further work had been completed to introduce the risk causes into the descriptions and would be included within the report at the next meeting. Mr Gibson reported work was ongoing to consider risk reporting and to improve the report that was presented from the Corporate Risk Register. Mr Gibson advised Committee Members were asked to consider the current extract and advise if there were additional areas of risk to be considered for inclusion in the risk register for Clinical and Care Governance Committee. Members had noted that it would be helpful if data on the likelihood and impact drivers of each risk was included within the extract. There was a question in relation to the target date of the Public Protection risk which was December 2021. It was noted it would be helpful from a governance perspective to consider the actions outstanding and by whom to establish an accurate reflection with time pressure. Mr Gibson agreed the next iteration of the report would include the likelihood, mitigation plans for each outstanding action point to build enhanced tracking. There was a question regarding which Committee the Acute Service unscheduled care risk was aligned to. Mr Gibson confirmed it was included within the Acute Services Committee Register. Ms Brimelow thanked Mr Gibson for the update on the Corporate Risk Register. The Committee were assured that the risks were clearly described and scored appropriately. **NOTED**		

			ACTION BY
10.	**BOARD CLINICAL GOVERNANCE FORUM - MINUTES OF MEETINGS**		
a)	**Approved minute of Board Clinical Governance Forum Meeting of 8 November 2021** The Committee considered the approved minute of the Board Clinical Governance Forum that was held on 8 November 2021 [Paper No. BCGF(M)21/06]. Ms Brimelow noted there were significant mental health challenges identified within their update and it was positive to see they were being addressed. Ms Brimelow advised a mental health update would be presented at the next meeting. **NOTED**		
11.	**BOARD INFECTION CONTROL COMMITTEE - MINUTES OF MEETINGS**		
a)	**Approved minute of Board Infection Control Committee Meeting of 9 December 2021** The Committee considered the approved minute of the Board Infection Control Committee that was held on 9 December 2021 [Paper No. BICC(M)]. Ms Brimelow highlighted the governance around the Partnership Infection Control Support Group (PICSG) having not had a meeting for six months. Ms Devine advised a new Chair had been nominated by Ms Rodgers and meetings would recommence in the near future. Ms Devine advised a review of all Committee structures was on the work plan for the coming year with key stakeholders and partners. **NOTED**		
12.	**CLOSING REMARKS AND KEY MESSAGES FOR BOARD**		
	Ms Brimelow thanked Committee members and those who had presented papers for the constructive discussion and provided a brief overview of the key messages;		

			ACTION BY
	- The Committee noted the update provided within the overview and the recruitment challenges highlighted within Oncology NHS Tayside. The Committee noted the fatal accident enquiry which would commence in the coming months on a child protection case due to severe neglect. - The Committee noted the Acute Services Clinical Governance report which demonstrated the clinical governance arrangements. The Committee were assured by the robust detail of reporting which positivity highlighted that meetings were well attended, continued throughout COVID-19 recently re-establishing a full agenda and the excellent engagement with SNAP. - The Committee noted the early development of the Acute Flow Navigation Centre described as the virtual front door for unscheduled care. The Committee were assured by the robustness of the processes and governance outlined in the report which converted unscheduled care to urgent planned care. - The Committee noted the Care Home Collaborative Governance and Assurance update. The Committee were assured by the framework and governance arrangements in place, recurring funding and satisfied by the early positive results. - The Committee noted two HAIRT reports for September - October 2021 and November - December 2021 and the challenging outbreaks in GRI Ward 64. The Committee were assured by the good multidisciplinary working and positive outcome and noted the AOP targets and the need for review through the remobilisation plan. - The Committee noted the extract from the Corporate Risk Register and were assured that the risks were clearly described and scored appropriately. The Committee noted the likelihood and impact scores would be reviewed and target dates would be considered for enhanced tracking. - The Committee noted and were assured by the Board Clinical Governance Forum minutes of the meetings held 8th November 2021. - The Committee noted and were assured by the Board Infection Control Committee minutes of the meeting held on 9th December 2021. - The Committee noted the Director of Clinical Governance had reviewed the annual cycle of business to ensure key clinical topics were included at future meetings. Ms Brimelow thanked members for attending and closed the meeting. **NOTED**		

			ACTION BY
13.	**DATE OF NEXT MEETING**		
	Tuesday 7 June 2022 at 2.00 pm, via MS Teams.		