

**Meeting of the Oxford Health NHS Foundation Trust**

**Quality Committee**

BoD 146/2018

(Agenda item: 14c)

Minutes of a meeting held on

Wednesday, 12 September 2018 at 09:00

in the Leylandii Room, L&D Unipart, Cowley OX4 2PG

|  |  |
| --- | --- |
| **Present[[1]](#footnote-1):** |  |
| Jonathan Asbridge  Stuart Bell  Bernard Galton  Mark Hancock  Dominic Hardisty  Martin Howell  Aroop Mozumder  Kerry Rogers  Martyn Ward | Non-Executive Director (**JAsb**) (the Chair)  Chief Executive (**SB**)  Non-Executive Director (**BG**)  Medical Director (**MHa**)  Chief Operating Officer (**DH**)  Trust Chair (**MH**)  Non-Executive Director (**AM**)  Director of Corporate Affairs & Company Secretary (**KR**)  Director of Strategy & Chief Information Officer (CIO) (**MW**) |
| **In attendance[[2]](#footnote-2):**  Jill Bailey  Rob Bale  Vivek Khosla  Britta Klink  Pete McGrane  Kate Riddle  Hannah Smith  Sula Wiltshire  Deborah Darch | Associate Clinical Director, Oxford Healthcare Improvement Centre (**JB**)  Clinical Director and Consultant, Adult Directorate/Oxfordshire Mental Health (**RB**) (*part meeting*)  Clinical Director and Consultant, Forensic Services/Buckinghamshire Mental Health (**VK**)  Head of Nursing, Adult Directorate (**BK**) (*part meeting*)  Clinical Director, Older Peoples Directorate (**PMcG**)  Deputy Director of Nursing (**KRi**)  Assistant Trust Secretary (**HS**) (Minutes)  Director of Quality, Oxfordshire CCG (**SW**)  Executive PA to Medical Director (**DD**) (Minutes) |

|  |  |  |
| --- | --- | --- |
| **1.**  a | **Apologies for Absence** Apologies for absence were received from: Ros Alstead, Director of Nursing and Clinical Standards; Tim Boylin, HR Director; Sue Dopson, Non-Executive Director; and Mike McEnaney, Director of Finance. | **Action** |
| **2.**  a  b  c  d  e  f  g  h  i  j | **Presentation from the Caring & Responsive Sub Committee**  The Chief Operating Officer introduced the presentation and handed over to RB and BK to present on Care Programme Approach (**CPA**). RB gave an overview of CPA and associated responsibility for individuals’ care. All patients were to have a care package with regular reviews of care to be clearly documented. This would be a live document and at point of handover, a package transfer meeting (with a named risk assessment and review date) would be required. Currently both CPA patients and non-CPA patients had a care coordinator. Requirements were subject to audit. However, a recent audit had highlighted that although Older People’s services had achieved a ‘good’ rating, other areas required improvement. BK referred to the national standards around review criteria. The Trust had opted to undertake six-monthly reviews in line with good practice; key standards parameters had been achieved.  Work was ongoing to support the process to record CPA in the electronic health record. This included working with JB and the Oxford Healthcare Improvement/Quality Improvement team to improve the assessment forms process. The CPA policy was also under review; a revised version had been circulated for comments by the Effectiveness quality sub-committee and would be discussed at its next meeting in October.  The meeting agreed the importance of clarifying who needs to be on CPA, especially for patients with complex needs or who required multidisciplinary team involvement. The Chair commented that allocation should be at the first assessment point, with ongoing decision-making supported with input from multidisciplinary teams.  BK noted that the application of the CPA framework alongside regular audits had grown into a lengthy process which was not applied in a standard way as there were now many elements to focus on. It was also challenging to achieve oversight of the Trust’s position on CPA process. However, dashboards were progressing to give a more accurate picture and the Care Quality Commission (**CQC**) inspection had not highlighted this as an issue.  The Chief Executive commented upon CPA in the context of providing quality care and as a tool to support clinical practice, noting that the process to use CPA and to monitor its consistent use should be simple.  The meeting discussed the use of CPA as a tool for quick assessment and also for improving care. RB noted that there was also a risk that it could be perceived by clinical staff as an administrative burden. AM suggested that by removing the elements of administrative burden, a more useable system could be developed. SW commented on the perception of core tasks versus administrative tasks and asked how this could be turned around so that the process was seen in a more positive light. The meeting noted the importance of supporting teams, reviewing the skill mix in teams and the roles which could be played by administrative support and associate practitioners.  The Director of Corporate Affairs & Company Secretary commented on the audit outcomes and what could be done differently. The review of the CPA policy was an opportunity to revisit methodology and peer review documentation. RB noted the importance of embedding consistent recording of CPA as best practice but explained that there were challenges for clinicians in following recording processes on the electronic health record. Work was therefore taking place to update the assessment tab on the electronic health record to make the system more user-friendly.  The meeting recognised that, over time, the breadth and length of CPA audits had expanded but it was now necessary to refocus upon non-CPA patients and monitor patient care across the population of CPA and non-CPA patients. The meeting clarified that CPA did not have a CQUIN (commissioning for quality innovation) payment attributed to it.  ACTION: to update the Committee on: progress to address concerns around CPA (including clarifying which patients needed to be on CPA) and consistent recording; and the review of the CPA policy.  **The Committee noted the presentation.** | **RB/KRi** |
| **3.**  a  b  c  d  e  f  g  h  i | **Minutes of the meeting on 11 July 2018 and Matters Arising**  The Minutes at paper QC 33/2018 were agreed subject to the following:   * p4 – item 2(u) Public Health Group – “Forensic services were looking to prescribe e-burn” replace “prescribe” with “enable”; and * p5 – item 4(b) Effectiveness Sub Committee Annual Report -   “Aroop Mozumder stated that antipsychotic monitoring needed to improve, and asked how this was being monitored”.  The above was incorrect in the July minutes as the issue was regarding high dosage above normal guidelines and monitoring to ensure appropriate checks and balances in place.  ***Matters Arising***  **Item 13 - Oxfordshire Night Team**  The Chair noted further concerns and some specific operational questions which had been put to him out-of-session by governors, including members of the Council of Governors’ Safety and Effectiveness sub-group, in relation to Oxfordshire Night Team services:   * if telephone calls were not recorded electronically, what written records were taken and how records were audited; * whether care coordinators, or the relevant duty team, followed-up the next day on any calls made by existing service users during the night; * whether existing service users could telephone their appropriate ward during the night; * what training was given to Out Of Hours (**OOH**) GPs; * what effect the Safe Haven crisis centre (run by the Trust’s partners, Mind and Elmore) was having; and * whether the Committee was assured that the Oxfordshire Night Team service was adequate and being monitored correctly.   The Chair suggested that the more operational questions above may be appropriate for the Executive and the relevant team to consider. The Chief Operating Officer agreed to take the questions back to the team and consider in more detail. However, it was also noted that the Night Team was making the best use of available resources and service monitoring was in place, including around the Safe Haven. Jane Kershaw, Head of Quality Governance, had also been working with Vanessa Odlin, Service Director, and the Patient Experience team to put in place a mechanism to collect random feedback from service users who may access Night Team services; themes and trends from this data would be analysed and reported back. The Chief Executive added that the Board was aware that the team was doing the best it could with the available resources.  The Chair reminded the meeting of the Committee’s delegated responsibilities from the Board and its broad remit, under its terms of reference, especially in relation to:   * providing assurance that appropriate policies, procedures, systems, processes and structures were in place and being implemented to ensure that services were safe, effective and efficient; * approving changes in clinical or working practices or the implementation of new clinical or working practices; * monitoring and ensuring action was taken on the quality, effectiveness and efficiency of services and identifying any associated risks; and * monitoring the development of clear quality outcomes.   The meeting discussed the Committee’s remit and responsibilities. Committee members and attendees at the meeting considered whether they were assured that appropriate systems, processes and structures had been put in place to address concerns raised in relation to the Night Team. The Committee, like the governors, was keen to: receive assurance that the Safe Haven was helping those service users who may previously have sought support from crisis services; and learn from analysis of patient and carer experience feedback. The Committee concluded however that the current plan of work which had been put in place provided sufficient assurance that appropriate action was currently being taken. Committee members would also visit the new assessment hub at the Littlemore site and the coordination centre, before the next meeting.  The Committee requested a full report on progress made against the governors’ concerns/questions above – for six months’ time (February 2019) to allow adequate time for improvements to bed in and to collect feedback.  The Committee discussed processes for concerns to be raised and feedback given. The Chief Executive noted that it was important to follow appropriate processes for escalating concerns through the governance framework and established groups/meetings in order to use time and resources effectively and maintain an appropriate audit trail. SW added that this was also an opportunity to check processes and understanding of how to utilise them. The Director of Corporate Affairs & Company Secretary would respond to governors to acknowledge the concerns which had been raised.  The Committee noted that the following actions would be held over for future updates/reporting:   * 10 May 2017 - 14(i) – linking up care in relation to eating disorder patients; * 11 July 2018 – 4(c) – report on the monitoring of antipsychotic medication; and * 11 July 2018 – 11(a) – Children & Young People’s Directorate Quality Report.   The Committee confirmed that the remaining actions from the Summary of Actions had been completed, actioned or were on the agenda for the meeting: 7(g) – update on Helen House; 14(b) – Dementia Strategy; 10(a) – Older People’s Directorate risks; and 15(a) – presentation on the Quality & Performance Assurance Framework. | **DH**  **All**  **DH**  **KR** |
| **Quality Improvement and Performance** | | |
| **4.**  a  b  c  d  e | **Safety Quality Sub Committee escalation report**  The Deputy Director of Nursing presented paper QC 34/2018 and explained that the Terms of Reference (**ToR**) had been reviewed and only minor changes required, as referred to in the report. She highlighted areas of good practice, including submission of all investigation reports to commissioners on time. Areas of risk/concern included:   * recruitment and retention challenges leading to high levels of agency usage and the need for wards to change their skill mix in order to maintain staffing levels; * further work required on the management and oversight of medical devices; * two ‘never events’; * two Coroners’ Regulation 28/Prevention of Future Deaths (**PFD**) reports during 2017/18 and two to date during 2018/19; and * an outbreak of an invasive group A streptococcal infection amongst seven people in West Oxfordshire.   The meeting discussed the ‘never events’, noting that these would also be included in the Chief Executive’s report to the Board in September. The meeting discussed the cases which had led to the PFD reports during 2018/19, noting that external investigations had also been commissioned which would add to the Trust’s learning.  The report also referred to positive developments in fire safety controls and assurance, with an annual fire safety assurance report having been submitted to the Audit Committee. BG reported that the Audit Committee had reviewed the fire safety report at its meeting on 11 September 2018 and, whilst acknowledging the work which was taking place, had not yet been assured by the situation around fire and evacuation drills. Although there had been helpful assurance in the fire safety report and evidence that the team had been doing good work with the resources which were available, the Audit Committee had noted that there was more work to do especially around leadership, embedding of procedures around fire and evacuation drills and alarm testing. The Audit Committee supported the actions which were being taken and planned but had requested that the Quality Committee also keep the area of fire safety and related fire risks under review and potentially consider an in-depth review of this area in due course (see also item 14(b) below).  AM referred to the likelihood of the Trust’s CQC rating for the ‘Safe’ domain remaining as ‘Requires Improvement’ and asked about plans to improve this and the respective roles of the Quality Committee and the Safety quality sub-committee. The Deputy Director of Nursing replied that this could be considered further under the agenda item on the CQC update.  **The Committee noted the report.** | **JAsb**  **KRi/JK** |
| **5.**  a  b  c  d | **Mental health homicide and domestic homicides update**  The Deputy Director of Nursing presented paper QC 35/2018 which provided a 6-month update of homicides across Oxfordshire and Buckinghamshire where either the perpetrator or the victim was known to the Trust, including one homicide where the person’s treatment had not yet transferred to Trust care.  The Chair asked about support for staff who were involved in these cases. The Medical Director acknowledged that court processes could be difficult for staff, especially when courts required transcripts of interviews. RB confirmed that staff were supported through a variety of means including being accompanied by RB and VK to inquests and court hearings.  The Chief Executive asked why the report referred back to cases from April 2011 against which all actions were recorded as having been completed. The Deputy Director of Nursing to clarify.  **The Committee noted the report.** | **KRi** |
| **6.**  a  b  c  d  e  f  g  h  i  j  k  l | **CQC Well Led inspection - update**  The Deputy Director of Nursing provided an oral update and reported that the Trust had received an overall ‘Good’ rating with individual ‘Good’ ratings for the Well Led, Caring, Responsive and Effective domains. The Safe domain remained rated as ‘Requires Improvement’. The CQC’s final inspection report had been published at the end of August 2018, for the inspection completed in April 2018.  Five Core services had been rated as ‘Good’ overall: Community LD; Acute & PICU; AMHTS; Older Peoples MH wards; and health based Place of Safety. Three Core services had been rated as ‘Requires Improvement’: Evenlode; Community Inpatients; and Urgent Care.  The Trust was developing its action plan in relation to 15 core actions and 47 ‘should’ actions. This would be reviewed by the Executive before submission to the CQC by: 21 September for Mental Health Services; and 05 October for Community Services.  Service leads had provided feedback for the CQC on the outcomes of the inspection. The CQC had also requested feedback on improving the factual accuracy process; this had been provided by the Trust.  Actions in progress:   * action planning by Directorate leads, supported by Priti Naik, Lead for CQC Standards & Quality, and the Deputy Director of Nursing; * a learning session with the CQC to improve the Provider Information Request/intelligence gathering process - for 13 September 2018; and * a quality summit with senior leaders, the CQC and NHS Improvement for 01 November 2018 to review improvements from the recent inspection and how the Trust can move to delivering ‘Outstanding’ care across every service.   Further to AM’s query at item 4(d) above, the Committee discussed oversight of actions further to the CQC inspection and plans to improve on the ‘Requires Improvement’ rating for the Safe domain. The Trust Chair emphasised the importance of this Committee receiving regular updates on progress against actions from the CQC inspection until all actions had been completed; he noted that there should not be a repeat of any instances where actions from a previous inspection remained outstanding.  The Chair noted that there continued to be focus upon community hospitals. He asked whether there was a community hospitals’ strategy. PMcG explained the distinction between: (i) a system-wide strategy which included community hospitals as part of system planning; and (ii) a clinical strategy for community hospitals, from which could be developed various operational plans, approaches to rehabilitation, plans to reduce length of stay and to reduce unwarranted variations in care. The Chair noted that it would be interesting to hear more in the future about a clinical strategy for community hospitals, in particular where it related to quality of care in community hospitals and plans for staffing.  *BK and RB left the meeting at 11.10.*  BG suggested that all CQC actions from the past three years should be consolidated in one place and tracked. The Deputy Director of Nursing replied that this was in progress with the CQC action plan which also linked into Estates actions from CQC Mental Health Act visits.  The Deputy Director of Nursing reported that the CQC would also be following up on its Oxfordshire system-wide health and social care review over 05-06 November 2018. The system response and improvements made would be considered. A workshop was scheduled on 14 September 2018 to consider further.  The Deputy Director of Nursing referred to the GP OOH inspection from April. The IC5 group had been monitoring the action plan and good progress had been made; actions were currently being completed within expected timescales but the anticipated onset of winter pressures meant that there was a risk of slippage, especially in relation to waiting times. The IC5 group would escalate any exceptions to the Executive.  The Chief Executive added that although it was important to have a clear clinical strategy for community hospitals, there was still an issue with the current hiatus over the future direction for community hospitals (whilst the CCG consultation was pending). This uncertainty also had the potential to impact upon the quality of services and should be considered in relation to the CQC system-wide review. An effective system-wide strategy together with a clinical strategy for community hospitals could, however, become mutually reinforcing. The Chief Operating Officer cautioned against pre-judging the outcome of the consultation process.  **The Committee noted the oral update.** | **KRi** |
| **7.**  a  b  c  d | **Oxford Healthcare Improvement (OHI) Centre update**  JB presented paper QC 36/2018 on the rapid expansion of improvement work at OHI including the development of internal project work, external collaborations and events. The report also referred to projects which had not progressed. JB provided a further update on the reasons why the two projects listed had not progressed:   * the ward with the gerontology project had already engaged another clinical consultant and whilst it was dealing with capacity and demand issues, this was not the time to undertake the project; and * the HR project had identified issues with the approach and methods to be used, especially around data collection and ownership. It had been agreed not to progress this project further.   The Chair referred to the ‘highly reliable ward’ project and asked whether this could also translate into a supportive approach for the ward which had not progressed the gerontology project. JB noted that the ward which had undertaken the ‘highly reliable ward’ project had undertaken improvement work in the past and had been particularly well versed in it.  AM asked what proportion of projects were prompted by national level recommendations and what proportion were more self-directed or innovative. JB replied that 4 were national pieces of work whilst the remainder were self-directed. BG commented positively upon the growth of the OHI Centre and the development of scholars and leadership cohorts.    **The Committee noted the report.** |  |
| **8.**  a  b  c  d | **Patient Experience and Involvement annual report**  The Deputy Director of Nursing presented paper QC 37/2018. Although feedback from patients, families and carers was generally overwhelmingly positive, she highlighted how themes from complaints (around communication and information sharing with families) were also mirrored in suggestions for improvement from feedback received. She reported that the Patient Experience & Involvement Manager was also working more closely with the Complaints team to triangulate learning and with young ambassadors; she was also involved in co-production work with Oxfordshire county council.  The Chair noted the importance of publicising to patients and their families how seriously their feedback was taken. He asked whether it was published. The Deputy Director of Nursing replied that it was publicly available and also presented to the Board in public.  SW added that patient experience work was an area of good practice for the Trust and that the team was to be congratulated. The Chair agreed and thanked Patient Experience & Involvement Manager.  **The Committee noted the report.** |  |
| **9.**  a  b | **End of Life Care / Respite Care update**  PMcG noted that a further update on Helen and Douglas House may be required in the future.  **The Committee noted the oral update.** | **PMcG** |
| **10.**  a  b  c  d | **Effectiveness Quality Sub Committee escalation report and ToR**  The Medical Director presented paper QC 38/2018 which also included the ToR and workplan for the Effectiveness quality sub-committee.  He highlighted that:   * the most recent CQC inspection had identified deficiencies with temperature monitoring of fridges and clinic rooms. He explained that the issue was more around the practice of monitoring and maintaining a record than the temperatures achieved; * in relation to the Mental Health Act, there had been an improvement in increased consideration of Community Treatment Orders (**CTOs**). However, there had also been increases in the number of detentions allowed to lapse and in the amount of Section 17 leave granted. The CQC had noted that the Trust had a higher than average use of Section 17 leave. This was linked to established practice and local clinical preference to use Section 17 leave rather than CTOs. However, this resulted in patients on Section 17 leave being categorised as inpatients and, therefore, any incidents linked to them also being categorised as inpatient incidents; and * concerns around attendance at mandatory training. These had also been discussed with the Chief Operating Officer who had suggested increased operational focus and support from managers to help staff to set aside the time to attend training. In discussion with colleagues at another trust, the Chief Operating Officer had noted the impact that regular follow-up had achieved. The Trust had also achieved an improvement in take-up of Information Governance training through doing more follow-up but this was time and resource intensive.   The Committee discussed the membership and wide remit of the Effectiveness quality sub-committee, with approximately 10 sub-groups reporting in. Whilst this could be challenging to manage, there could also be issues with attendance or provision of reports – previously from Learning & Development, HR and Estates. However, attendance had improved and Clinical Directors in particular were well represented.  **The Committee noted the report**. |  |
| **11.**  a  b  c | **Clinical Audit annual report**  The Medical Director presented paper QC 39/2018 and reminded the Committee that this had also been referred to at the previous meeting in July 2018, as part of the presentation from the Effectiveness quality sub-committee.  The Chair noted that the improvement was encouraging. The Deputy Director of Nursing noted that the two new clinical audit specialists had been making very positive contributions through setting up workshops, training and engaging with staff. Links were also being made with the Trust’s improvement work; the Lead for Quality & CQC Standards was also one of the OHI’s improvement scholars.  **The Committee noted the report.** |  |
| **12.**  a  b  c  d  e | **Caring & Responsive Quality Sub Committee escalation report**  The Chief Operating Officer presented paper QC 40/2018 to which was also appended the Family, Friends and Carers Annual Report 2018. The progress made on the Trust’s strategy for Family, Friends and Carers was highlighted as an area of good practice and elements were well under way, as summarised in the appended Annual Report. The first annual Carers’ Conference had also been held, and well received, in May 2018.  The Chief Operating Officer also highlighted areas of concern:   * arising from the self-assessment against the Triangle of Care Family, Friends and Carers best-practice toolkit as services had reported a lack of dedicated resources to be able to realise the Trust’s vision. A volunteer programme in this area was being piloted to remedy this; * related to continued problems identified during CPA audits. It was intended to run a focused session to better understand and resolve these; and * continued difficulties meeting statutory and contractual targets for Delayed Transfers of Care. However, he reported that he was optimistic of finding a solution through efforts across the system.   The Chief Operating Officer drew the Committee’s attention to the recommendation that the Caring & Responsive quality sub-committee give over its next session to a workshop on the revised CQC standards for Caring & Responsive to ensure that these were fully understood and that appropriate assurances were sought in the future to meet these revised standards. As a result, the Caring & Responsive quality sub-committee may report in a different way to the next meeting of the Quality Committee. In relation to regular business, the intention was to circulate papers as normal and discuss any urgent escalations, but devote the majority of time to the revised CQC standards.  The Chair referred to the good practice cited in the report from Complaint Review Panels which represented a ‘deep dive’ into a random sample of complaints and provided opportunities for learning and improvement. He suggested that it would be helpful to have more detail on these or a presentation at the next meeting to understand the assurance received and the types of issues which the team addressed. The Chief Executive suggested as an alternative that the Chair gain some direct experience by attending one of the Complaint Review Panels; he noted that previously Non-Executive Directors had attended these panels. The Chair agreed this approach to attend a Complaint Review Panel in person.  **The Committee noted the report**. | **JAsb** |
| **13.**  a  b  c  d | **Well Led Quality Sub Committee escalation report**  The Chief Executive presented paper QC 41/2018 and noted that the Well Led quality sub-committee still intended to increase directorate representation at the meeting from team leaders and to connect more with the initial cohort from the Leadership Development Programme.  He highlighted areas of particular focus in relation to:   * Equality and Diversity and ensuring that the WRES (Workforce Race Equality Standards) were well publicised and understood; * ‘closing the loop’ on whistleblowing by ensuring that not only were investigations conducted and recommendations responded to but also that learning was embedded and cultural change achieved. Now that retrospective data was available looking back over several years, it was appropriate to seek another level of assurance; * retention of trainee nurse associates; and * improving upon recording of supervision for the Trust as a whole. Although there was confidence at local levels that supervision was taking place, central recording needed to be improved if the Trust was to be able to demonstrate readily and effectively that it was taking place. This was relevant for facilitating CQC inspection processes and had also been relevant evidence in one of the inquests which had resulted in a PFD report. The Director of Strategy & CIO would also be considering this as part of routine performance management.   He noted that the Well Led quality sub-committee had also considered support for staff from the EU in anticipation of Brexit, as an aspect of emergency preparedness and further to local system discussions. Teams with a higher proportion of staff from the EU may need more support than others and the risk of more staff leaving across the health and social care sector may impact upon the system as a whole.  **The Committee noted the report**. |  |
| **14.**  a  b  c  d | **Operational and Strategic Risks – Trust Risk Register (TRR) and Board Assurance Framework**  HS presented paper QC 42/2018 and highlighted: progress made against ‘extreme’ rated risks; the escalation of new ‘extreme’ rated risks from the Older People’s Directorate; the inclusion of new ‘high’ rated risks from Pharmacy and Estates; and the potential inclusion of a new ‘high’ rated risk in relation to the end of the Section 75 Partnership in relation to Older Adult Mental Health.  Noting the discussion at item 4(c) above, the Committee discussed the fire evacuation risk on the TRR. The Deputy Director of Nursing provided an update that the risk had recently been discussed between the Fire Safety team and Estates; roof space/compartmentation works were scheduled for 2018/19 and mitigating actions were in place in relation to evacuation plans and to ensure that staff were appropriately trained and aware. PMcG noted that the risk may need to be tested further in the Directorate to ensure that it was appropriate for escalation. The Chief Executive welcomed this in case it had been overstated. BG noted that the Audit Committee, following receipt of the annual fire safety assurance report, had noted some areas to focus on.  The Committee agreed the inclusion of the new ‘high’ rated risk on the TRR in relation to the end of the Section 75 Partnership in relation to Older Adult Mental Health and the pressure which this could put upon the remaining service and team. The Chief Executive noted that there was also a potential wider impact upon the system if the Trust was not able to treat as many patients as a result but that responsibility for this risk was not just held by the Trust.  The Committee discussed the risk which had been escalated from Pharmacy to the TRR in relation to implementation of the Falsified Medicines Directive (**FMD**). The Chair explained the FMD to the Committee. The Chair noted that the report was comprehensive and provided supporting detail which triangulated with matters discussed at the Board and in other committees.  **The Committee noted the report and confirmed the inclusion of the suggested new risks.** |  |
| **15.**  a  b | **Quality Committee annual report 2017/18**  The Director of Corporate Affairs & Company Secretary presented paper QC 43/2018 and corrected the report by explaining that the ToR had not been updated this time. As part of developing committee effectiveness, she noted how annual reporting processes could become more than a reflection/reiteration of the previous year but could analyse the effectiveness of decisions taken and whether taking a different approach could have resulted in a different outcome. She cited the CQC inspection as a potential example and whether review of particular areas or actions in more detail could have impacted upon outcomes. The Chief Operating Officer noted the importance of the quality sub-committees aligning themselves with the revised CQC standards and providing assurance against each relevant standard.  **Subject to the correction above, the Committee received the report and recommended it for final approval by the Board.** |  |
| **16.**  a  b  c | **Quality and Performance Assurance Framework (presentation)**  The Director of Strategy & CIO gave a presentation on the Quality and Performance Assurance Framework and explained how this was being created to try to align performance and risks against various performance indicators. The three principle aims were: assurance, integration and review. Although currently within a developmental phase, the intention was to maximise the various business intelligence tools available to the Trust and integrate performance and informatics. He demonstrated the dashboards/dynamic reporting which could be created and the way in which data could be drilled down and challenged at a granular service-line level. He explained the benefits of a multi-purpose monitoring tool to support consistent reporting across areas and to capture live data.  SW asked when this form of reporting would be available. The Director of Strategy & CIO replied that it would be tested through the Board meeting in private session initially and, subject to further development, future performance reporting may be converted into this new style.  **The Committee noted the presentation.** |  |
| **17.**  a | **Any Other Business**  The Committee discussed the benefits of having a joint member on both the Audit Committee and the Quality Committee and agreed that, for the time being, BG would continue to attend meetings of both committees; from the end of September he would be taking on the role of Chair of the Audit Committee. |  |
|  | There being no further business to discuss, the meeting closed at: **12:45**  **Date of next meeting: Wednesday 14 November 2018 09:00-12:00 in the Leylandii Room, L&D, Unipart Conference Centre Level 5**  ***\*\* Safety Sub Committee in attendance*** |  |

**Attendance 2018 - 2019**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Members (quorum)** | **May 2018** | **July 2018** | **Sept 2018** | **Nov 2018** | **Feb 2019** |
| *Non Executive Directors (minimum 4 as members)* | | | | | |
| Jonathan Asbridge |  |  | *✓* |  |  |
| Aroop Mozumder |  |  | *✓* |  |  |
| Bernard Galton |  | *x* | *✓* |  |  |
| Sue Dopson |  | *x* | *x* |  |  |
| Martin Howell |  |  | *✓* |  |  |
| *Executive Directors (Quality Committee membership includes the Executive Directors)* | | | | | |
| Stuart Bell |  |  | *✓* |  |  |
| Mark Hancock |  |  | *✓* |  |  |
| Ros Alstead |  | *Deputy* | *x* |  |  |
| Dominic Hardisty |  |  | *✓* |  |  |
| Mike McEnaney |  | *x* | *x* |  |  |
| Tim Boylin | x | x | x |  |  |
| Kerry Rogers |  |  | ✓ |  |  |
| Martyn Ward | x | x | ✓ |  |  |
| **Attendees** |  |  |  |  |  |
| Jane Kershaw |  |  |  |  |  |
| Kate Riddle |  |  | *✓* |  |  |
| Rob Bale |  |  | *✓* |  |  |
| Pete McGrane |  |  | *✓* |  |  |
| Viki Laakkonen |  |  | *x* |  |  |
| Hannah Smith |  |  | *✓* |  |  |
| Kirsten Prance |  |  | *x* |  |  |
| Jill Bailey |  |  | *✓* |  |  |
| Vivek Khosla |  |  | *✓* |  |  |
|  |  |  |  |  |  |
| Sula Wiltshire | *Deputy* |  | *✓* |  |  |

1. Members of the Committee. The membership of the committee will include the executive directors and 4 non-executive directors. The quorum for the committee is five members to include the chair of the committee (or the vice chair of the committee in their absence), one non-executive and one executive director. Deputies will count towards the quorum and attendance rates. [↑](#footnote-ref-1)
2. Non-member attendees and contributors [↑](#footnote-ref-2)