

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

**Quality Committee**

BOD 68/2019

(Agenda item: 19(a))

Minutes of a meeting held on

Wednesday, 13 February 2019 at 09:00

in the Conference Room, POWIC Building, Warneford Hospital, Oxford OX3 7JX

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| **Present[[1]](#footnote-1):** |  |
| Jonathan Asbridge | Non-Executive Director (**JAsb**) (the Chair) |
| Stuart Bell | Chief Executive (the **CEO/SB**) |
| Dominic Hardisty | Chief Operating Officer (the **COO/DH**) |
| Mark Hancock | Medical Director (the **MD/MHa**) |
| Martin Howell | Trust Chair (**MH**) – *part meeting* |
| Aroop Mozumder | Non-Executive Director (**AM**) |
| Martyn Ward | Director of Strategy & Chief Information Officer (the **DoS/CIO/MW**) |
| **In attendance[[2]](#footnote-2):** |  |
| Rob Bale | Clinical Director, Oxfordshire & BSW Mental Health Directorate (**RB**)  |
| Claire Dalley | Director of Estates & Facilities (**CD**) – *part meeting* |
| Jane Kershaw | Head of Quality Governance (**JK**)  |
| Donna Mackenzie | Patient Experience & Involvement Manager (**DM**) |
| Vanessa Odlin | Joint Service Director, Oxfordshire & BSW Mental Health Directorate (**VO**) – *part meeting* |
| Kirsten Prance | Associate Clinical Director - Learning Disabilities, Specialised Services Directorate (**KP**) |
| Catherine Sage | Head of Mental Health – Urgent Care & Social Care, Oxfordshire & BSW Mental Health Directorate (**CS**) – *part meeting* |
| Mark Taylor | Lead Clinician – Special Care Dentistry, Specialised Services Directorate (**MT**), *deputising for Ros Mitchell – part meeting* |
| Hayley Trueman | Oxford Healthcare Improvement (**OHI**)Centre – Safety & Quality Improvement Lead (**HT**), *deputising for Jill Bailey - part meeting* |
| Helen Ward | Deputy Director of Quality, Oxfordshire CCG (**HW**), *deputising for Sula Wiltshire* |
| Liz Williams | Service Director – Learning Disabilities, Specialised Services (**LW**) |
| Hannah Smith | Assistant Trust Secretary (the **ATS/HS**) (Minutes)  |

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| **1.**a | **Apologies for Absence** Apologies for absence were received from the following Committee members: 1. Tim Boylin, HR Director;
2. Sue Dopson, Non-Executive Director;
3. Bernard Galton, Non-Executive Director;
4. Mike McEnaney, Director of Finance;
5. Kate Riddle, Acting Director of Nursing & Clinical Standards; and
6. Kerry Rogers, Director of Corporate Affairs & Company Secretary.

Apologies and absences were noted from the following regular attendees: 1. Jill Bailey, Associate Clinical Director, Oxford Healthcare Improvement;
2. Rami El-Shirbini, Clinical Director – Forensic Services, Specialised Services Directorate;
3. Vivek Khosla, Clinical Director, Buckinghamshire Mental Health Directorate;
4. Pete McGrane, Clinical Director, Community Services Directorate;
5. Neil McLaughlin, Inquests, Claims & Risk Manager; and
6. Ros Mitchell, Clinical Director – Dentistry, Specialised Services Directorate.
 | **Action** |
| **2.**ab cdefghijklmn | **Minutes of the meeting of the Quality Committee on 14 November 2018 and Matters Arising** The Minutes at paper QC 01/2019 were approved as a true and accurate record.***Matters Arising*****Item 2(i) Diabetes management in the Trust**The MD explained that there was not a Diabetes committee or steering group but that the Deputy MD had been looking into diabetes management. Once the Deputy MD had provided an update then the MD would report into this Committee. The Chair agreed. **Item 2(m) Reporting on retention in the Safer Staffing report to Board – particularly in relation to community mental health teams**Jane Kershaw noted that the action remained to provide more reporting on retention, especially in relation to community mental health teams, in the Safer Staffing report to the Board. The Chair added that it may also be interesting in due course to consider Staff Survey results in relation to community mental health teams. The CEO noted that the Executive was currently reviewing the preliminary Staff Survey results and although this could be broken down by team, the data was not as precise or as subjective as from Safer Staffing reporting. **Item 2(m) Patient or Staff Story to Board – from community mental health**Jane Kershaw confirmed that a Story from a community mental health team was being scheduled for reporting to the Board in the next 6 months. **Item 4(b) Executive Director attendance levels at the Committee meeting** The Chair noted that even though a number of the apologies and absences for today’s meeting related to sickness absence, especially during the winter period, directors in particular should nominate a deputy to attend in their absence. The Committee discussed recent absences and acknowledged that attendance at meetings with regulators was important but that deputies could still attend Committee meetings and report back on discussions and decisions made. The CEO added that discussions which took place through this Committee informed the Trust’s commitments and direction of travel as well as providing a forum for participation in dialogue and decision-making; he emphasised the importance of attendance. Aroop Mozumder added his concern and noted the importance of the subjects discussed and that assumptions should not be made that if enough other colleagues were present then attendance may not be necessary. The Trust Chair added that the importance of attendance at this meeting, or of providing a deputy, should be raised at the next Board meeting. **Item 4(d) Oxfordshire Night Team**The meeting noted that a presentation from the Oxfordshire Mobile Night Team was on the agenda for the meeting, at item 12 below, and that the service remained a topic for discussion at the recent Patient Experience sub-group meeting of the Council of Governors. Jane Kershaw added that the service had also been discussed with Oxfordshire CCG. The Chair asked about discussions with commissioners to fund crisis services generally, noting that commissioners should be held to account to support such services and that the Trust was not currently commissioned to provide these. The CEO confirmed that the Trust was discussing with commissioners in Oxfordshire and Buckinghamshire to set up emergency and crisis treatment teams but although the responses had been positive, it could still take time to initiate and set up. **Item 4(g) End of Life Care/Respite Care (Helen and Douglas House) – to contact the CCG in relation to the closure of Douglas House and the impact on access to Continuing Healthcare services**The Chair reported that further to discussion with the CEO, they had agreed that the CEO would raise this with the CCG in the context of wider system discussions around the model of care. **Item 8(c) Bladder Scanners – to contact the CCG to request support**The Chair reported that he had also agreed that the CEO would raise this with the CCG. **Item 13(a) Reporting to the Board on Personal Development Reviews (PDRs)/appraisals**The DoS/CIO explained that data was available for reporting on PDR compliance but that the format and the forum should be considered. The Trust Chair emphasised the importance of PDRs and reflected that, given challenges achieving compliance over the years and the importance of improving this, he recommended that reporting be provided directly to the Board. The CEO agreed and noted that reporting on PDRs would be provided to the Board as well as to the Well Led quality sub-committee; this Committee was also kept updated on PDR compliance as this was the subject of an action from the Care Quality Commission and a quality objective in the Quality Account, both of which were already reported into this Committee as per items 3 and 4 below. Rob Bale added that the directorates were working to conduct PDRs and follow-up on any which were overdue. The Chair noted that the key to achievement was ensuring that the message was conveyed through directorates and out to all staff. The DoS/CIO to report on PDR compliance to the Board in February or March. **Item 13(c) Oxford Pharmacy Store (OPS)/Pharmacy reporting around quality (in particular in relation to the General Pharmaceutical Council (GPhC) or the Medicines and Healthcare Products Regulatory Agency (MHRA)**The Chair reminded the meeting that the Falsified Medicines Directive had recently come into force. He requested that OPS/the Pharmacy team report into the next meeting on compliance with medicines regulations and quality matters. The Trust Chair noted that although OPS already separately reported into the Finance & Investment Committee on financial performance, it was also important to develop reporting on quality matters given previous issues. *Claire Dalley joined the meeting*. **Item 15(c) Directorate Quality Reports**Jane Kershaw and Rob Bale confirmed that they had been developing this reporting for the new directorates. Rob Bale reported that once the format had been confirmed then the Oxfordshire & BSW Mental Health Directorate would be the first to present its Directorate Quality Report, to be followed in subsequent meetings by the Community Services Directorate and then the other directorates. **Item 22(b) Section 75 Joint Management Groups (S.75 JMGs) and impact of changes in the provision of Social Care**The COO reported that although Oxfordshire County Council had withdrawn its proposals to cut £1 million from its contribution to the Outcomes Based Contract for Mental Health in Oxfordshire, it had still approved a £600,000 cut to the S.75 funding for adult Social Care staff (although the implementation of this had been deferred for a year until April 2020). The CEO noted that this amounted to cuts equating to 17 social workers from adult community teams in Oxfordshire, which was the equivalent of capacity to treat approximately 425 patients. Rob Bale added that staff were already unsettled and the prospect of losing 17 staff members would result in rethinking how the model of care would be delivered. The CEO noted that this would also be conside red further as part of contractual discussions with Oxfordshire CCG, given the deficit that this could create in the Trust’s capacity to treat and support patients. The Chair noted the importance of reporting on S.75 JMGs remaining a standing item on the agenda and asked whether there were statutory responsibilities for the Committee to be mindful of. Rob Bale replied that S.75 responsibilities included delivery of a statutory social care function and that the implications of the changes were that the Trust would remain responsible for carrying these out but on a reduced budget. The Committee noted that the following action was held over for future update: item 12(d) from 12 September 2018 – the Chair to attend a Complaints Review Panel. The Committee confirmed that the remaining actions from the Summary of Actions had been completed, actioned or were on the agenda for the meeting: * item 14(i) from 10 May 2017 – in relation to linking up care for Eating Disorder patients, the COO confirmed that this was part of ongoing discussions with universities and that meetings were taking place with Oxford Brookes University. The action was noted as for removal from the Summary of Actions document;
* item 2(d) – infection control and the state of cleanliness of the Trust – on the agenda as the Cleaning Standards report at paper QC 04/2019, item 6 below;
* item 5(e) – distinguishing between CQC “must” and “should” actions in reporting - complete and on the agenda at paper QC 03/2019, item 4 below;
* item 7(d) reporting on High Dose Antipsychotic Treatment (**HDAT**) – included as part of the Effectiveness report at QC 10/2019, item 14 below and referred to in the OHI Centre report at QC 07/2019, item 9 below;
* item 11(a) – Draft Quality Oversight Framework (presentation on the agenda at item 5 below); and
* item 14(c) – bullying and workforce issues – scheduled for the Board Seminar in April 2019.
 | **KRi****JAsb****MW****MME/****MHa** **RB and clinical directors** |
| **Quality Improvement and Performance** |
| **3.** abcde | **Quality Account** Jane Kershaw presented the report QC 02/2019 which provided an update on the 2018/19 quality objectives and suggestions for the 2019/20 quality objectives; she confirmed that a draft of the Quality Account would be provided to the next meeting in May 2019 and explained the timescales as part of the Trust’s year-end reporting including the Annual Report & Accounts. She noted that the Council of Governors’ strategy session on 28 February 2019 would also review the quality objectives. In relation to progress against the 2018/19 quality objectives, although actions within each objective were on schedule and progressing well, it was more difficult to demonstrate the impact of some of the actions. For example, the impact of the Workforce Strategy upon turnover and vacancies. She noted that any objectives which were not fully achieved in 2018/19 would be carried forward and aligned with the objectives for 2019/20. Aroop Mozumder emphasised the importance of demonstrating impact and outcomes. He noted that whilst there was emphasis upon delivery of strategies and proposals, regulators would be looking for evidence of progress and impact as well as realistic assessments of where progress had not been made. Jane Kershaw noted that it could take more than a year from implementation of strategies to being able to demonstrate impact but that challenges to make progress were not from lack of commitment or actions. The CEO added that benchmarking data, for example in relation to incidents of violence and aggression, could also be used to help to demonstrate impact in relation to quality objectives such as improving patient experiences and patient safety. The Chair noted the importance of the Quality Account being able to bring alive what the impact of the quality objectives meant for patients and staff. He added that it would also be useful to receive feedback on comments provided by the governors following the Council of Governors’ strategy session. **The Committee noted the report and that the draft Quality Account document would be presented to the next meeting.**  | **JK****JK** |
| **4.** abcdefgh | **Care Quality Commission (CQC) actions update report**Jane Kershaw presented the report QC 03/2019 which provided an update on progress against the CQC “must do” actions as well as progress against the three Trust-wide “should do” actions. Further to discussion at item 2(i) above, the “should do” actions included one that all staff have a PDR/annual appraisal booked or completed by 31 March 2019. The Trust continued to have regular contact and quarterly engagement meetings with CQC inspectors. The Trust’s programme of internal peer reviews and “mock” CQC inspections continued, most recently with community hospitals where every ward had received a visit from an independent team. She explained that some actions remained categorised as open or in progress until audits had taken place to confirm that actions had been embedded; a deliberately cautious approach was being taken to ensure that completion could be evidenced, even though actions had taken place. The Chair expressed concern about the length of time that certain actions remained open and in progress, in particular in relation to waiting areas, pain assessments and medicines temperature monitoring. He emphasised the importance of not failing to complete actions between one CQC inspection and the next and noted that pain management in particular should be a critical part of care which was delivered. The meeting discussed actions in relation to the Urgent Care service (pp.2-3) to: * provide a separate waiting area for children in the Witney Minor Injuries Unit and sufficient and appropriate seating to meet the needs of patients. Claire Dalley reported that although the separate waiting area was not yet complete, before Christmas 2018 an additional waiting area and an increased number of seats had been provided; she also received regular property maintenance reports which confirmed that there tended to be no more than 20 people waiting in the 30-seat waiting area so far; and
* ensure that patient information on computer screens was not visible to visitors or other patients. The DoS/CIO noted that although reconfiguring workspaces had proven difficult, computer screen covers/protectors were being purchased which should resolve this.

The meeting discussed actions in relation to Community Hospitals (pp.3-4) to:* assess and monitor pain for all patients using a recognised pain assessment tool. A pain assessment and management tool had been relaunched across the service and a pain re-assessment prompt was due to go live on CareNotes during February 2019. Liz Williams noted however that, when visiting wards during internal peer reviews, staff were not yet using the tool although this may be because the prompt was not yet live on CareNotes. Peer reviews had been assured that patients were being well cared for and knew what their options were to manage pain however recording of this on CareNotes needed to be implemented;
* store all medicines at appropriate temperatures. Claire Dalley confirmed that the Estates and Pharmacy teams working together had ensured that temperature sensors/tiles had been provided for every fridge that stored drugs in the Trust. The sensors collected temperature data which was reported back to the Pharmacy team. The sensors were also being rolled out to drugs rooms and capital expenditure had been earmarked for air conditioning to be installed in some rooms. As more data was made available through the rollout of the sensors, the Trust would have a clearer understanding of where temperatures were being exceeded and where action should be concentrated; and
* develop and implement a strategy for Community Hospitals inpatients. The CEO noted that although the wider healthcare system did not yet have a strategy, the Trust could give a clear view on direction of travel for Community Hospitals and Minor Injuries Units which it could feed into wider system discussion. The DoS/CIO and Jane Kershaw added that a draft strategy for Community Hospitals was also in development.

The Chair noted that although the discussion had provided some reassuring additional detail, in particular as pain management had been considered through internal peer reviews, it was still concerning that: (i) actions such as pain assessment and monitoring remained open on the agenda for discussion and had been there for some time since the previous inspection; and (ii) there had been no representation at this meeting from the Community Services Directorate. He recommended that the quarterly engagement meetings should be used to inform CQC inspectors on the actions being taken and the progress which had been made. The CEO confirmed that this did take place. Aroop Mozumder added that although there had been progress on some actions, it was concerning that there had been completion on few; he recommended that there be more definitive and positive moves towards completion and a reduction in the number of actions currently marked as dependent upon other factors before completion could be recorded. The Chief Executive agreed and noted that slower progress did not necessarily denote drift away from actions but it was important to evidence commitment and completion; the Trust was close to being able to demonstrate completion of actions and he would also be concerned if it was not able to maintain current progress and activity. The Chair noted that the Committee was not yet assured about the pace of progress and that he would escalate this for further discussion at the Board meeting in private session on 27 February 2019 and he requested attendance from the Community Services Directorate.  **The Committee noted the report**. *Mark Taylor (deputising for Ros Mitchell in Dentistry) joined the meeting*.  | **DH/ PMcG** |
| **5.**abcd | **Draft Internal Quality Oversight Framework**Jane Kershaw gave a presentation on the Draft Internal Quality Oversight Framework which was being designed to support delivery of high quality person-centred care. She explained that this would not replace existing performance, activity or quality reports but that it would help to focus attention upon service lines which may be less visible, where there could be less assurance or routine reporting and where there could be gaps. The Framework was part of wider work to improve triangulation of information at service line level and was being developed alongside a new integrated and interactive information platform/dashboard being developed by the Business Information Team. The meeting discussed risks around generating large quantities of data, and the extra work this could lead to, but without sufficient analysis or triangulation to be able to use it for assurance. Jane Kershaw explained that the Framework was being aligned with the dashboard being developed by the Business Information Team so as to be able to support analysis. Whilst it was not intended to lead to more work, once it had been populated then discussions could take place with directorates in order to understand if there were information gaps in relation to one of the 47 service lines. The DoS/CIO added that the principles behind the Framework were to join up performance measurement with controls and evidence quality. This could be achieved through setting out the framework within which the Trust operated and then aligning performance measures within this in order to demonstrate quality. The CEO added that when the ‘never event’ in Children’s services (to be discussed at item 7 below) had happened, it had also become apparent that because there had not been many incidents in that service previously, the service had not been as scrutinised as other services; the Framework may help to provide more comprehensive coverage and scrutiny of all service lines. Aroop Mozumder asked what would trigger the Framework to provide a positive assurance rating for a particular service line and whether this would be linked to an internal definition or to a national measure of assurance. Jane Kershaw replied that the Framework would benefit from access to more sources of information than national measures, including access to real time information. Positive assurance ratings could be triggered by various factors including national clinical audit results, CQC inspection ratings and the results of Mental Health Act visits, complaints data, patient feedback, waiting times, incidents and risk registers. **The Committee noted the presentation**.  |  |
| **6.**abc | **Cleaning Standards report** Claire Dalley presented the report QC 04/2019 on the standard of cleaning provided by NHS Property Services (**NHSPS**) across properties occupied by the Trust. Audits conducted over April to December 2018 had identified that cleaning standards had fallen short of the Trust’s requirements, as set out in the report. NHSPS had recognised that this was not an acceptable position and, having been unable to resolve the situation with their cleaning supplier, had transferred domestic services inhouse where they could be monitored by more local managers. The Estates team would monitor standards through monthly audits and monthly meetings with NHSPS. The Chair asked which committees or groups within the Trust’s Integrated Governance Framework received regular reporting on cleaning standards in order to supervise the situation and the monitoring taking place through Estates. Claire Dalley replied that this was reported to the Safety quality sub-committee (which reported directly into this Committee) and the Infection Prevention Control and Decontamination Committee. The Chair agreed this was appropriate but noted that, should cleaning standards not improve then this Committee would expect to receive escalation reporting on this from the Safety quality sub-committee chaired by the Acting Director of Nursing & Clinical Standards. **The Committee noted the report.** *Claire Dalley left the meeting*. |  |
| **7.**ab | **Children’s Integrated Therapy Service – ‘Never Event’ actions update**Jane Kershaw presented the report QC 05/2019 and reported that an update on progress against the action plan had been provided to the Coroner and that the Clinical Director for the Community Services Directorate continued to maintain contact with the family to offer ongoing support. Two actions which had not yet completed were detailed in the report – one was anticipated to complete by March 2019 once an update to CareNotes had gone live; and the other was pending Estates’ work to create a further team base (for which business cases had been approved). **The Committee noted the report**. *Hayley Trueman (deputising for Jill Bailey) joined the meeting.*  |  |
| **8.**abcd | **Healthcare access for people with Learning Disabilities and Autism**Liz Williams presented the report QC 06/2019 on the NHS Improvement ‘Provider Improvement Standards’ for all trusts in relation to healthcare access for people with Learning Disabilities and Autism. The report set out the Trust’s self-assessment against the new standards and included some focus on epilepsy. The NHS Improvement benchmarking report was not yet available but the Trust had fully participated in the benchmarking data collection exercise; once the bespoke benchmarking report for the Trust was available then the Trust’s annual reporting on Learning Disabilities would refer to it and baseline actions against it, progress against which would be reported quarterly. She highlighted that the Trust’s Learning Disability services were recognised as innovative and working well, although there was still more work to do. The report was also accompanied by two Quality Review reports for Learning Disability services provided to the CCG.The Chair noted that it would be useful to see the NHS Improvement benchmarking report when it was available. Aroop Mozumder asked whether support for families of people with Learning Disabilities would be included as part of the Physical Health Strategy. Kirsten Prance replied that the implementation plan for the strategy covered this broadly and included interfacing with Oxford University Hospitals NHS FT through a hospital liaison role. Liz Williams added that although usually acute hospital liaison was a part time role, in Oxfordshire there was access to 1.7 WTE of a role which equated to more access to liaison nurses who could help patients and their families to navigate care pathways than some other areas. **The Committee noted the report** **and that benchmarking from NHS Improvement would be reported when available.**  | **LW/KP** |
| **9.**abcde | **Oxford Healthcare Improvement (OHI) Centre – update report**Hayley Trueman presented the report QC 07/2019 and highlighted the work which had taken place on HDAT monitoring, as set out in section 3 of the report on projects requested and undertaken. She noted that different teams undertook HDAT monitoring in different ways and that there was no central database for patients on HDAT; the Prescribing Observatory for Mental Health (**POMH-UK**) audit had focused more on physical health checks for inpatients. The MD added that the POMH-UK audit had been exclusively focused upon inpatients and had been the first attempt nationally to consider the issue but it had not reviewed outpatients. Rob Bale noted that there was a clear process on inpatient wards for HDAT monitoring and that he and the Clinical Director for the Buckinghamshire Mental Health Directorate had reviewed this and been assured that inpatient teams were aware of HDAT monitoring processes. An audit was being written up for city teams so that learning could start to be disseminated but there were still potential risks, especially if GPs prescribed HDAT for non-psychiatric reasons. The MD added that HDAT prescribing had also been set up as a risk alert on CareNotes. Hayley Trueman asked if the OHI Centre should be involved in further work around HDAT monitoring. The MD replied that the OHI Centre had been asked to review the current state and suggest improvements; ultimately however the most complete solution would be through implementation of e-Prescribing. A number of e-Prescribing packages had been identified which could provide this and which would be considered further through finance and procurement processes. Hayley Trueman asked if an e-Prescribing package would monitor the green warning stickers which were put on drug charts for patients on/at risk of HDAT to prompt regular review. The MD replied that an e-Prescribing package could produce these/their equivalent so that monitoring would be inbuilt. The Chair asked whether, in the interim and pending procurement of e-Prescribing, the MD was assured that the Trust was complying with good practice around HDAT. The MD confirmed that he was more assured in relation to inpatients but noted that there could always be risks with GPs prescribing to outpatients in addition to medication which the Trust had prescribed. The meeting discussed primary care systems for flagging risks around prescribing and noted that these may still be reliant upon data being provided to GPs and then manually inputted into GP patient records. The Chair noted that the OHI Centre was not required to undertake further work on HDAT in relation to inpatients and that if there were concerns then the MD should escalate these from the Effectiveness quality sub-committee. The MD confirmed that HDAT reporting would remain part of his regular Effectiveness report. He added that he had suggested that the OHI Centre be involved in the implementation of an e-Prescribing solution, once procured. The DoS/CIO noted that e-Prescribing was just one business change to undertake and that work may also be required to ensure that all related activities were joined up to analyse potential risks and weaknesses and to support delivery of an effective solution. **The Committee noted the report and that future reporting on HDAT would remain through the Effectiveness quality sub-committee.** |  |
| **Committee effectiveness** |
| **10.**abcdefghi | **Discussion item: how do we differentiate between compliance and improvement as we mature as a Quality Committee**The Chair introduced the discussion and noted that whilst a significant proportion of the work of this Committee from its Terms of Reference focused on securing assurances around regulatory compliance, the Committee did not as often consider what Quality Improvement activity was taking place in the Trust and how the OHI Centre could be put to better use. He noted that reporting on Quality Improvement work taking place in directorates should be reported in from directorates who should own this work, especially as they were accountable for improving services to their patients. This Committee should also, however, have oversight of Quality Improvement activity taking place and make recommendations to directorates to commission Quality Improvement activity which may be inspired by compliance and other reporting received by the Committee. This Committee should progress to drive Quality Improvement. ***Directorates’ ownership and reporting of Quality Improvement activity***Liz Williams noted that when, for example, the Learning Disabilities services reviewed the outcome of its Quality Improvement work or work led through the OHI Centre then there should be a mechanism for it to be shared with other services and directorates so that learning could be transmitted to fertilise other Quality Improvement projects. It would be important, therefore, for negative as well as positive outcomes to be shared for there to be effective learning. Rob Bale referred to the development of Directorate Quality Reports (at item 2(k) above) and noted that these had been the conduit through which updates on directorate improvement work and other projects had been reported. Once the format for the new reports to align with the new directorates had been confirmed then these reports could enable this Committee to receive a broad spectrum update on directorate performance and quality activity. The Chair agreed that the Directorate Quality Reports would be appropriate to bring this focus and demonstrate directorates’ ownership of Quality Improvement activity. Jane Kershaw added that it was also important to recognise that the burden should not just be upon the OHI Centre to report in isolation upon improvement activity taking place but that this should be done alongside directorates. There was a different challenge however with reporting on the more Trust-wide improvement work taking place.***Board and Committee oversight and assurance***The Chair asked which of the quality sub-committees reviewed the work of the OHI Centre in most depth. The CEO replied that this was through the Well Led quality sub-committee. The Chair requested more visibility of the work of the OHI Centre, noting that he had been made aware through Professor Charles Vincent, Director of the OHI Centre, of a new training programme which should benefit managers and administrators as well as clinicians and thereby support the spread of a broader spectrum of improvement expertise through the organisation. He noted that work/training programmes such as this should be made more visible to the Board.The meeting discussed whether Quality Improvement activity taking place in directorates and the work of the OHI Centre should be considered in more detail through a Board Seminar, or another forum, and whether that would provide this Committee and the Board with sufficient assurance on progress being made to improve services for patients. The Trust Chair noted that a Board Seminar may not be the preferred forum but that Linking Leaders Conferences may offer a broader opportunity for discussion. The Chief Executive noted that a recent Linking Leaders Conference had focused upon Quality Improvement already. The Trust Chair explained that he was suggesting that this could become a regular item on the agenda for such conferences. The meeting noted that there was a risk of Linking Leaders’ agendas become overcrowded and being put under pressure to cover a lot of material without necessarily being able to achieve enough. The meeting considered instead this Committee holding a more focused session/time-out on the theme of Quality Improvement. The Chair noted that he would consider this further and discuss with Charles Vincent. Aroop Mozumder asked how the focus of Quality Improvement work could link more with the Trust’s extreme and high-rated risks. Rob Bale replied that this was through Directorate Risk Registers and the work of Clinical Directors to identify and highlight key risks, for example around capacity to deliver care to patients and caring for staff. He noted that whilst the Trust was considering improvement work, due to the challenge of Demand exceeding Capacity it was also having to consider ceasing delivery of some care and instructing staff accordingly. He noted that this could be an area of consideration for the OHI Centre and when developing improvement initiatives. ***Compliance vs Improvement***The CEO commended the challenge to differentiate between compliance and improvement. He noted that whilst an overwhelming amount of NHS activity was driven by compliance requirements, this could drown out improvement activity such that it could become reduced to centralised reporting or reporting focused on ‘good news’ improvement stories rather than the more difficult aspects which Quality Improvement should be addressing. In this context, CQUIN (Commissioning for Quality and Innovation) targets risked becoming an unhealthy way of incentivising improvement activity. Instead, improvement activity should be owned by the various services across the Trust and there was an opportunity for this Committee to reinforce this, receive the reporting back from across the Trust and differentiate between compliance and improvement. This could also be assisted by the development of the Quality Oversight Framework as well as the separate dashboard being developed by the Business Intelligence team (as discussed at item 5 above) both of which could help to: provide a map of the Trust’s sources of oversight and assurance; and indicate where there could be gaps, especially if some services were identified as embracing Quality Improvement less inherently than others. The Chair concluded that he would consider further this Committee holding a more focused session/time-out on the theme of Quality Improvement. The next meeting however should have more dedicated time to Quality Improvement activity. Future reporting on Quality Improvement activity should also increasingly come from directorates, rather than centrally, through the new Directorate Quality Reports and accompanied by presentations from directorates. **The Committee noted the discussion and that the new Directorate Quality Reports would include reporting on Quality Improvement activity.**  | **JAsb****JAsb****RB and clinical directors** |
| **Escalation from quality sub-committees, directorates and risk registers** |
| **11.**ab | **Well Led quality sub-committee escalation report**The CEO presented the report QC 08/2019 and highlighted: * the reporting from the OHI Centre including on various training programmes such as the Demand & Capacity training;
* the update from Learning & Development – as the Trust was a provider of apprenticeships, it should also start to receive monitoring visits from Ofsted. These could have an impact upon the Workforce Strategy as should Ofsted deem there to be unsatisfactory progress in any area then the Trust would not be able to commence further apprenticeships (including those it delivered in collaboration, such as Nursing Associates);
* recording of compliance with PDRs, mandatory training and supervision remained an area of concern although there had been some slight improvements;
* the revised Probation Policy had been discussed and the Well Led quality sub-committee had requested that a more robust and less risk averse version be developed; and
* the Draft Patient Experience Strategy had also been considered and was recommended for review by this Committee and was on the agenda for this meeting at paper QC 14/2019.

**The Committee noted the report**.  |  |
| **12.**abcdefgh | **Oxfordshire Night Team**Vanessa Odlin and Catherine Sage joined the meeting and gave a presentation on the Oxfordshire Night Team, setting out: the staffing and the model for the team; activity engaged in (which also varied depending upon need); incidents and concerns raised (there had been no formal complaints raised through the complaints process in the period June 2018 to February 2019); the outcome of a patient experience survey conducted during October-November 2018, including feedback received from patients; and developments for the team and the service. The main components of the role of the Night Team were to provide: (i) leadership support to inpatient wards; and (ii) a continuation of Adult Mental Health Team ‘step-up’ care overnight but without leaving hospital premises. The CEO confirmed that the Trust was discussing with commissioners setting up emergency and crisis treatment teams and being funded to provide more of an Out Of Hours service. The Chair noted that progress was being made towards the Trust’s contracts being extended to cover more emergency and crisis provision. The meeting discussed concerns which had been raised by governors through Council of Governors’ sub-group meetings. Vanessa Odlin reported that she had attended governors’ meetings, shared her contact details and invited governors to contact her directly especially if they received feedback about the team which it could be useful to pass on; she emphasised that she welcomed contact and wanted to be appraised on any available details of feedback. The meeting considered the incidents reported which included aggression and verbal abuse towards staff (the largest category), damage to hospital property, self-harm, aggression by a patient towards their family and an incident involving communication between the Night Team and the Adult Mental Health Team. Catherine Sage clarified that the communication incident had been reported by the Night Team after the Adult Mental Health Team had not followed through with a plan for a patient. There had been no formal complaints in the period June 2018 to February 2019. The meeting considered the patient experience survey during October-November 2018 when the Night Team had sought consent from service users to be contacted by the Patient Experience & Involvement Manager to provide feedback. The meeting noted the divergence between service users’ expectations of the team and what the team was able to do and meant to be delivering. This was especially the case when service users wanted home visits, which the team was not able to do, and exacerbated when service users made contact in a crisis. Vanessa Odlin emphasised the importance of the team clarifying expectations at the start of contact with service users. The meeting discussed options for service users to access face to face contact and support including through the Assessment Hub and the Oxford Safe Haven. Funding for the Oxford Safe Haven was not permanent but Vanessa Odlin reported that it had been of significant benefit to the team in reducing the number of contacts from more regular presenters. The Chair asked whether any governors had accepted invitations to visit the Assessment Hub. Vanessa Odlin replied that some carers who were also governors had visited the Assessment Hub. Catherine Sage added that, in the interim whilst the Trust was discussing investment in a Crisis Resolution and Home Treatment Team, the existing service was exploring how to use its current available resource differently, for example the possibility of using Skype or FaceTime calls to provide face to face contact without leaving hospital premises. This could be similar to the facility already offered in the Emergency Department Psychiatric Liaison Service. *The Trust Chair left the meeting*. The meeting discussed actions and developments for the team and the service. It was noted that the Consultant Nurse in Suicide Prevention would be undertaking a block of nights in March working with the Night Team to provide skills development. Rob Bale added that work was also underway to review how people with personality disorder were supported in the community as the way in which the complex patient pathway operated in the system may be escalating behaviours and leading to people wanting to call for reassurance several times during the night; he noted that the Oxford Safe Haven may be able to provide an outlet for this which would then allow the Night Team to offer a different level of help beyond responding to emotional distress. Vanessa Odlin reminded the meeting of the challenges faced by the staff on the Night Team, especially whilst the team was trying to be everything for everyone and the impact which this could have upon individuals. She noted that opportunities to develop inpatient leadership and duty manager cover overnight should be explored so that the different inpatient and community roles of the Night Team could be separated, which could help with delivery of care and to increase capacity. **The Committee noted the presentation and that the Night Team would be discussed further at the Council of Governors’ meeting in March 2019.** *Vanessa Odlin and Catherine Sage left the meeting*.  | **DH/VO/CS** |
| **13.**ab | **Caring & Responsive quality sub-committee escalation report** The COO provided an oral update and reported that an extraordinary meeting of the Caring & Responsive quality sub-committee had recommended that its responsibilities be separated out into two separate quality sub-committees - one to focus on the CQC standard of ‘Caring’ and the other upon ‘Responsive’. Although the current Caring & Responsive quality sub-committee was assured that standards were substantively being met and that any gaps had been identified, it was concerned that the breadth of the agenda for the ‘Responsive’ standard in particular was too large for the existing structure to continue, especially if there needed to be increased focus upon waiting lists and access times. **The Committee discussed and AGREED: (i) the need to create separate Caring and Responsive quality sub-committees; and (ii) that the DoS/CIO should chair the Responsive quality sub-committee.**  |  |
| **14.**abc | **Effectiveness quality sub-committee escalation report** The MD presented the report QC 10/2019 and highlighted:* improvement in delivery of the Clinical Audit programme and credited the Head of Quality Governance and noted that the corporate audit team was now more stable than it had been previously;
* the work of the Drugs and Therapeutics Group on:
	+ implementation of the temperature monitoring system for fridges, as discussed at item 4 (e) above;
	+ developing CareNotes to support monitoring of HDAT, as discussed at item 9(a) above. The report also provided more detail on monitoring of patients subject to HDAT and review of six e-Prescribing solutions; and
	+ updating dementia guidelines to reflect NICE guidance;
* the outcome of monitoring of patients transferred under section 136 of the Mental Health Act had been that the 24-hour period had rarely been exceeded and the new legislation had generally caused few difficulties outside of Child & Adolescent Mental Health Services; and
* progress to complete the Information Governance Toolkit submission and concerns that rates of completion were currently 81% but the Trust needed to have achieved 95% by the end of March 2019.

 Aroop Mozumder referred to page 9 in the report and asked why the Trust had one of the highest rates of detention on inpatient units, as confirmed by national benchmarking. The meeting noted that capacity to manage these high numbers of patients subject to the Mental Health Act was an issue within the Mental Health Act Office (managing the documentation for detention and increasing numbers of Community Treatment Orders) and for frontline staff. The MD replied that Adult Mental Health Teams were being presented with more acute cases and community teams were dealing with higher levels of acuity and these pressures were now transferring to inpatient wards. The CEO added that the Trust had high thresholds for admission but was operating at a time when the system was under high pressure; it was therefore only possible to admit the most acute patients but at a time when they were most unwell. He noted the impact upon this of diminished capacity in mental health teams and issues with lack of funding for crisis and home treatment but that the solution would not lie with more inpatient beds. Rob Bale added that the data also demonstrated the positive effect of early treatment through the Improving Access to Psychological Therapies service, when the Trust was able and funded to provide this. The Chair noted the Committee’s concern with the situation and that it supported the Executive to progress discussions with commissioners. **The Committee noted the report, including the further reporting on HDAT, and the challenges in managing Demand and Capacity pressures.**    |  |
| **15.**abc | **‘Effective Clinical Governance for the Medical Profession’ – update on handbook**The MD provided an oral update and explained that he had discussed with the liaison officer for the General Medical Council who had confirmed that the handbook had been developed in the wake of an investigation into a surgery case which had highlighted that some trust boards may not be clear on the role of the responsible officer. The handbook therefore set out to clarify the responsible officer role and medical HR processes but was not intended to increase reporting. The MD confirmed that he was assured that Trust processes were robust and that the Board was appropriately informed. The Chair noted that the national discussion had now moved on and a consultant oversight framework committee had been set up to review the independent sector in particular and how practising privileges were granted. The MD added that mental health services had fewer instances of private practice than other sectors and that appropriate Trust processes and a policy were in place. **The Committee noted the oral update**.  |  |
| **16.**ab | **Safety quality sub-committee escalation report**Jane Kershaw presented the report QC 11/2019 and highlighted:* the Safety meeting had taken oversight of safe management of medicines, including storing and recording of fridge temperatures, and the Medical Devices Committee had been relaunched in December 2018 to further improve oversight and ensure compliance with MHRA requirements;
* actions being taken in relation to the risk identified in relation to fire evacuation drills and further to escalation from the Audit Committee. Every ward would complete a full or partial drill by the end of February 2019 and drill dates were being monitored, with non-compliance to be escalated to the Executive; and
* new national guidance on pressure damage reporting which would be implemented from 01 April 2019 and would change and increase levels of reporting.

**The Committee noted the report**.  |  |
| **17.**abcd | **Operational and Strategic risks discussion** The ATS presented the report QC 12/2019 on operational risks as set out in the Trust Risk Register and strategic risks in the Board Assurance Framework, noting the fire evacuation risk (at 1.15) which remained high-rated on the Trust Risk Register. The meeting considered the points of note from the Trust Risk Register set out on pp. 2-3. The MD referred to the new risk on scrutiny of admissions and the risk of illegal detention under the Mental Health Act (at 1.16) and confirmed that a volunteer had been identified to scrutinise the medical recommendations and thereby mitigate the risk. The meeting noted that a snapshot of directorates’ risk registers was unavailable pending migration of risks from the pre-October directorate structure to the new structure. Rob Bale highlighted the importance of issues around the number of Adult patients being sent on Out of Area Placements (**OAPs**) and the pressures upon staff which amounted to risks across directorate risk registers. Staff retention and recruitment risks remained high-rated and ‘likely’ on the Trust Risk Register (5.1-5.2). The meeting discussed the management of patients on OAPs and noted that these were taking place at present and being managed as active issues, rather than future risks; it was recognised that OAPs were not the preferred solution for patients and that work was taking place to manage and reduce these. Rob Bale noted that whilst the risk registers and risk discussions might highlight risks to future delivery, current issues such as OAPs should be higher on the agenda for discussions around quality of care. The Chair acknowledged this and noted that this would be relevant for consideration of the strategic direction of this Committee. **The Committee noted the report and, subject to the comments above on new mitigation to be included for risk TRR 1.16, confirmed the inclusion of new risks on the Trust Risk Register.**  |  |
| **Policy and Strategy updates** |
| **18.**ab | **Policies update**Jane Kershaw provided an oral update (paper QC 13/2019 was unavailable). She highlighted that out of 64 policies: 2 were red-rated and due for review; and 15 were amber-rated and, whilst due for refresh, they had been reviewed and found to be fit for purpose. She confirmed that the Acting Director of Nursing & Clinical Standards had contacted the responsible authors for the 2 red-rated and overdue policies in order to progress these. **The Committee noted the oral update**.  |  |
| **19.**abc | **Draft (Patient) Experience & Involvement Strategy**Jane Kershaw and Donna Mackenzie presented the draft (Patient) Experience & Involvement Strategy 2019-2021 at QC 14/2019 and confirmed that any actions not completed from the current strategy in place would be included within the 2019-21 strategy. The draft strategy was out for consultation until the end of March before it would be presented to the Board for approval. Donna Mackenzie explained that this strategy aimed to empower more co-design, co-development and co-production of services. The word “patient” had also been removed from the title of the strategy as the people the Trust worked with were not exclusively patients. The meeting discussed the need to provide a more public-facing and easy-read version of the strategy as well as a detailed version of the strategy, noting that more work may need to be done on an easy-read version in collaboration with the Learning Disability service and the Communications team. Jane Kershaw noted that a video would also be created to accompany the strategy. The Chair commended the brevity of the current version of the strategy which did set out the key information. **The Committee noted the draft Experience & Involvement Strategy and that a final version would be presented to the Board for approval after consultation had concluded in March 2019.**  |  |
| **Section 75 Joint Management Groups (JMGs)** |
| **20.**ab | **Minutes of the meeting of the S.75 JMGs for Oxfordshire and Buckinghamshire**The COO presented the minutes of the meetings for the Oxfordshire JMG from 09 October and 07 December 2018 at papers QC 15-16/2019 and for the Buckinghamshire JMG from 09 October 2018 and 09 January 2019 at papers QC 17-18/2019. He noted that key developments had already been discussed at item 2(l) above. **The Committee received the minutes.**  |  |
| **21.** a  | **Any Other Business** There being no further business to discuss, the meeting closed at: 12:36.**Date of next meeting: Wednesday 08 May 2019 09:00-12:30 in the POWIC Building, Warneford.** |  |

**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* | *✓* | *✓* | *x* |
| Sue Dopson  |  | *x* | *x* | *✓* | *x* |
| Martin Howell |  |  | *✓* | *✓* | *✓* |
| *Executive Directors (Quality Committee membership includes the Executive Directors)* |
| Stuart Bell |  |  | *✓* |  *x* | *✓* |
| Mark Hancock  |  |  | *✓* | *✓* | *✓* |
| Ros Alstead  |  | *Deputy*  | *x* | *✓* | *N/A* |
| Dominic Hardisty  |  |  | *✓* | *x* |  *✓* |
| Mike McEnaney  |  | *x* | *x* |  *x* | *x* |
| Tim Boylin  | x | x | x | x | *x* |
| Kerry Rogers  |  |  | ✓ | *✓* | *x* |
| Martyn Ward | x | x | ✓ | x | *✓* |
| **Regular Attendees** |  |  |  |  |  |
| Jane Kershaw |  |  |  | *✓* | *✓* |
| Kate Riddle |  |  | *✓* | *✓* | *x* |
| Rob Bale |  |  | *✓* | *✓* | *✓* |
| Pete McGrane |  |  | *✓* | *✓* | *x* |
| Viki Laakkonen  |  |  | *x* | *x* | *N/A* |
| Hannah Smith |  |  | *✓* | *✓* | *✓* |
| Kirsten Prance  |  |  | *x* | *x* | *✓* |
| Jill Bailey  |  |  | *✓* | *✓* | *x* |
| Vivek Khosla  |  |  | *✓* | *✓* | *x* |
|  |  |  |  |  |  |
| Sula Wiltshire | *Deputy*  |  | *✓* | *Deputy* | *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)