

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

**Quality Committee**

BOD 82/2019

(Agenda item: 14(a))

Minutes of a meeting held on

Wednesday, 08 May 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**) – *part meeting* |
| Bernard Galton | Non-Executive Director (**BG**) |
| Dominic Hardisty | Chief Operating Officer (the **COO/DH**) |
| Mark Hancock | Medical Director (the **MD/MHa**) |
| Aroop Mozumder | Non-Executive Director (**AM**) |
| David Walker | Trust Chair (**DW**) – *part meeting* |
| Martyn Ward | Director of Strategy & Chief Information Officer (the **DoS/CIO/MW**) |
| **In attendance[[2]](#footnote-2):** |  |
| Jill Bailey | Associate Clinical Director, Oxford Healthcare Improvement (**JB**) |
| Rob Bale | Clinical Director, Oxfordshire & BSW Mental Health Directorate (**RB**)  |
| Dorcas Dan-Cooke | Ward Manager – Ashurst PICU – *part meeting* |
| Rajwinder Gill | Deputy Ward Manager – Ashurst PICU – *part meeting* |
| Jane Kershaw | Head of Quality Governance (**JK**)  |
| Pete McGrane | Clinical Director, Community Services Directorate (**PMcG**) |
| Neil McLaughlin | Inquests, Claims & Risk Manager (**NMb)** |
| Michael Marven | Chief Pharmacist (**MM**) |
| Lorna McGuigan | Clinical Nurse Lead – Marlborough House Adolescent Unit – *part meeting* |
| Ros Mitchell | Clinical Director – Dentistry, Specialised Services Directorate  |
| Priti Naik | Lead for Quality and CQC Standards (**PN**) – *part meeting* |
| Pauline Scully | Deputy Chief Operating Officer (**PS**) – *part meeting* |
| Paula Stevens | Senior Health Care Assistant – Ashurst PICU – *part meeting* |
| Sula Wiltshire | Director of Quality, Oxfordshire CCG (**SW**) |
| Hannah Smith | Assistant Trust Secretary (the **ATS/HS**) (Minutes)  |

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| **Quality Improvement Presentations** |
| **1.** abcdefghijklmno | **Quality Improvement projects** **led through the Oxford Healthcare Improvement (OHI) Centre*****Safer Care Project – reduction in self-harm at Marlborough House, Swindon***Lorna McGuigan gave a presentation on the Safer Care Project to reduce self-harm at Marlborough House, Swindon. She highlighted the positive impact of changes to: * introduce twilight shifts, which involved an additional member of staff who would stay from the afternoon into the night shift and help to settle the young people on the unit in the evenings. This had responded to findings that 62% of incidents took place during the hours of 17:00-22:00 and 73% occurred over Monday-Thursday. Staffing numbers at the weekend could also be reduced as more patients were on leave;
* use the addition of the extra staff member to introduce more activities in the evenings; and
* install anti-climb fencing in the garden (completed in January 2019). Previously staff had been wary about using the outside space with the old fencing in place but since the new fencing had been installed, there had been no incidents of going Absent Without Leave from the garden.

The Committee commended the achievements of the project and noted the positive impact of changes such as introducing an extra member of staff at key times. The Chief Executive praised the work which had taken place but asked whether there was a risk of slipping back towards an increase in incidents now that the project had concluded, or whether the team was assured that the changes had been embedded. Lorna McGuigan replied that the changes were embedded and effective for the new patients on the unit but it was more challenging to introduce these to returning patients. She noted that part of the changes had also involved not automatically proceeding towards 1:1 observations following incidents; whilst this could be difficult it was ultimately intended to be empowering for young people. The Chair commented upon the positive difference which withdrawing from a situation rather than enforcing behaviours could lead to, noting that a similar approach had also been taken on Ruby ward.Sula Wiltshire asked whether the cohort of patients had demonstrated higher instances of autism. Lorna McGuigan replied that this had not yet been considered for this cohort of patients. Jill Bailey added that this had, however, been considered as part of a project on the Highfield unit and it had been found that incidents of self-harm were at equal levels across patient groups, not concentrated on those with a diagnosis of autism. The COO noted that when analysis of incidents of self-harm was considered, it would be useful to move away from the aggregate numbers currently reported and towards consideration of incidents per patient. As one patient could generate repeated incidents and therefore have a heavy impact upon figures reported, it would be useful to develop more run-chart and cluster analysis. Rob Bale noted that it was already possible to review this level of detail and identify spikes in incidents related to specific patients. The COO explained that it would be helpful to have that detail and analysis when presenting data to this meeting. The meeting discussed linking in this Safer Care work with the regular Trust-wide reporting on incidents which already took place. Jane Kershaw noted that quarterly analysis of incidents already took place which informed Safety & Quality reporting to the Board but it was difficult to focus upon all individual wards each time; current focus was upon reducing restrictive practice in the Trust.Aroop Mozumder asked about differences in rates of incidents of self-harm between patients who went home at the weekend and patients who stayed on the unit. Lorna McGuigan replied that the unit worked towards all patients being able to go home at weekends and to achieve full weekend-leave as quickly and safely as possible; patients with a higher risk of self-harm, however, may take longer to progress to being able to achieve full weekend-leave. The CEO asked about the support which the team had needed in order to undertake this work and noted that whilst it might be tempting to suggest that all units could achieve similar results just by undertaking a process of considering incident peaks and changing shift patterns, the situation could be more complex. Lorna McGuigan confirmed that the team had benefitted from a significant amount of input and support from the OHI Centre and that this had been invaluable in terms of collecting data and providing guidance through regular team meetings; it had also been key to have protected time for the project. Pete McGrane asked whether the findings of the project had confirmed what the team had suspected or had highlighted new issues. Lorna McGuigan replied that the findings had corroborated what the team had thought was happening. ***Reducing enhanced observations on the Ashurst Psychiatric Intensive Care Unit (PICU)*** Dorcas Dan-Cooke, Rajwinder Gill and Paula Stevens gave a presentation on the project to reduce enhanced observations on the Ashurst PICU. They explained that the issue had been that enhanced observations were frequent and time consuming but not always helpful; the rationale could be unclear to staff and patients; and, in relation to processes, whilst nursing staff could increase levels of observations, they could not decrease levels without medical input. To refine their understanding for the project, the team had created a simple spreadsheet to record observations details, using data from observations sheets and progress notes from CareNotes. The team had then implemented the following changes:* improved shift handovers through developing a new template to improve the shift handover process and how shifts were planned;
* observation huddles to identify patient needs and team actions and lead to more informed decision-making with patients and more open team discussion and reflection. The huddles were very team inclusive and involved Health Care Assistants (**HCAs**), Nurses and Allied Health Professionals (**AHPs**) such as Occupational Therapists; and
* development of an observation huddles template to standardise huddles and improve their overall quality.

The presenters highlighted positive outcomes from the project including:* no patient had had to return to enhanced observations when they had been taken off these following a nursing observation huddle;
* staff morale had improved and staff at all levels reported feeling empowered to discuss observations and had a clear understanding of the purpose of observations. Paula Stevens, as a Senior HCA, recounted her experiences of having her voice listened to through these huddles and how she had felt more empowered and part of the team;
* staff feedback about patient presentation was more accurate; and
* more positive engagement with patients under observation had been reported and the experience was becoming more purposeful and therapeutic.

*Priti Naik and the Trust Chair joined the meeting*. The presenters reflected upon lessons learned from the experience of undertaking a quality improvement project and emphasised the importance of: * establishing physical space for project work to minimise distraction from operational business;
* identifying a project lead but also allowing for some flexibility as team members grew into roles; and
* establishing protected time to work on the project within the team and also with the OHI Centre team.

Bernard Galton asked whether the project had also impacted upon staff sickness levels or use of agency staff. The presenters reported that the huddles also benefitted agency staff and new staff on shift by improving handovers and enabling all staff to easily engage with the relevant patient. As the new practices were also improving the quality of enhanced observations, this was anticipated to change nursing approaches and usage of temporary and agency staff. Sula Wiltshire commented positively upon how the project had demonstrated the importance of patient engagement and the value of a multi-disciplinary team. She asked about the impact of the project upon medical colleagues. Dorcas Dan-Cooke replied that there had been strong support from the ward consultant and the other medics on the ward; there was a flattened hierarchy on the ward and a level of trust in staff which had been further supported by the improvement in staff feedback about patient presentation (one of the positive outcomes of the project). She added that Paula Stevens, as a Senior HCA, had also led some huddles. Pauline Scully noted that although historically Nurses (not just medics) had used to take such decisions, as times had changed and in response to various incidents, policies had changed but it was encouraging to hear about the empowerment of nursing and AHP colleagues; she noted that often it could be the Nurses or HCAs who may notice the small details of changes in patient presentation which could be significant. Pete McGrane referred to the slide on the development of the observations huddle template and the note that this test of change was not supported by current policy. He recommended that the Trust’s policies and approach to policies should have more latitude built in to empower teams to try improvement work which might take them away from current policies.The CEO thanked the presenters from both Quality Improvement projects and noted that these were examples of what he had hoped for when embarking upon the OHI Centre. He emphasised the importance of person-centred care and empowerment of staff at all levels; as both patient and staff time was precious, it should also be used well. He reflected upon the strictures of adherence to policies and noted that overarching policies were still there for some good reasons. One ward or unit’s developments may not automatically transplant into another environment which might be doing things differently. The Chair thanked the presenters from both projects and praised the outcomes which benefitted both patients and staff. He noted that this item on the agenda also demonstrated the Committee’s commitment, as discussed at the previous meeting on 13 February 2019, to: drive Quality Improvement in the Trust; have oversight of, and consider in more detail, Quality Improvement activity taking place; and be able to make recommendations to directorates to commission Quality Improvement activity. He reminded the meeting of the discussion at the last meeting, as set out in the Minutes at paper QC 19/2019 (item 10), and that future reporting on Quality Improvement activity should increasingly come from directorates, rather than centrally, through the new Directorate Quality Reports and accompanied by presentations from directorates. *Lorna McGuigan, Dorcas Dan-Cooke, Rajwinder Gill and Paula Stevens left the meeting*.  | **Action****Clinical Directors** |
| **Introductory items** |
| **2.** ab | **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. Mike McEnaney, Director of Finance;
4. Kate Riddle, Acting Director of Nursing & Clinical Standards; and
5. Kerry Rogers, Director of Corporate Affairs & Company Secretary.

Apologies and absences were noted from the following regulator attendees: 1. Rami El-Shirbini, Clinical Director – Forensic Services, Specialised Services Directorate; and
2. Vivek Khosla, Clinical Director, Buckinghamshire Mental Health Directorate.
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| **3.** a | **Declarations of Interest**No new declarations but the Chair reminded the meeting of his position as Clinical Director at Healthcare at Home Ltd which provided services to the pharmaceutical industry and into the NHS in the form of pharmaceutical-funded NHS services, as relevant to the discussion at item 11 below.  |  |
| **4.**abcdefghi  | **Minutes of the meeting of the Quality Committee on 13 February 2019 and Matters Arising** The Minutes at paper QC 19/2019 were approved as a true and accurate record, subject to correcting a typographical error in item 1(b) to read “regular” rather than “regulator”. ***Matters Arising*****Item 2(c) Reporting on retention in the Safer Staffing report to Board – particular in relation to community mental health teams**Jane Kershaw noted that the action to provide more reporting on retention was not yet complete but the reporting to Board on Safer Staffing had started to include more detail around wards. **Item 2(k) and 10(i) Directorate Quality Reports (including coverage of Quality Improvement activity) to be presented, once formatting confirmed**Rob Bale noted that he intended to discuss the proposed template further with the Chair before presenting the Oxfordshire & BSW Mental Health Directorate Quality Report to the meeting; this would then be followed by the Directorate Quality Report for the Community Services Directorate and then the other directorates. **Item 4(g) Progress against Care Quality Commission (CQC) actions from the Community Services Directorate**The Chair confirmed that this action had been completed and that the Board meeting in private on 27 February 2019 had been assured by a presentation from the Community Services Directorate on progress against the CQC action plan. He noted that this action had demonstrated appropriate escalation when the meeting of this Committee had not received assurance. **Item 8(b) Learning Disabilities – reporting on NHS Improvement (NHSI) benchmarking** The COO reported that the NHSI benchmarking report was still not available and that timing depended upon NHSI. **Item 10(e) and (h) Quality Committee focused session/time-out on the theme of Quality Improvement**The Chair noted that he had contacted Charles Vincent, Director of the OHI Centre, to discuss this. **Item 12(h) Oxfordshire Night Team**The Chair noted that the action to discuss at the Council of Governors’ meeting on 20 March 2019 had been completed. The COO provided a further update that funding was expected for a crisis service in Buckinghamshire and he explained that this would indirectly benefit the Oxfordshire service by reducing overall demand. He noted that the Service Director and the Deputy COO were undertaking night time visits/visiting wards at night; the management team was also considering separating responsibilities so that staff providing night time cover were not also responsible for community night time support. The Chair concluded that this Committee was satisfied with the assurances which had been provided and noted that the Oxfordshire Night Team would remain under operational review. He commended the management team on the work they had done to review and support the Night Team and he noted that this was a good example of active involvement by Governors. The COO added that the Night Team staff should also be recognised and commended for their efforts; he recounted an example of a staff member actively following up on a case after they had gone off shift. 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 2(e) – Executive Director attendance at the Committee, as discussed at the Board meeting in private on 27 February 2019;
* item 2(i) – reporting to the Board on Personal Development Reviews/appraisals, as provided to the Board meeting in private on 27 February 2019;
* item 2(j) on Pharmacy and Oxford Pharmacy Store reporting – on the agenda for this meeting; and
* item 3(a) and (d) – draft Quality Account – on the agenda for this meeting.
 | **KRi/MC****RB and** **Clinical Directors****KP/LW****JAsb** |
| **Quality Improvement and Performance** |
| **5.** ab | **OHI Centre – update report** Jill Bailey presented the report QC 20/2019 which included progress updates on: * the development of the teaching and learning approach to build Quality Improvement capability in the organisation (80 staff had been trained across a range of Quality Improvement programmes);
* projects in discussion this quarter and although not all projects were listed, 18 open projects were in progress from directorates and services, there were 15 Improvement Scholars projects and a further 20 Improvement Scholars projects were anticipated together with another 20 frontline projects in August/September. She reported that the OHI Centre was reaching capacity to support projects and would need to focus on building Quality Improvement capability in order to enable others to provide support and leadership; and
* academic and other collaborations.

**The Committee noted the report and the progress being made by the OHI Centre.**   |  |
| **6.**abcd | **CQC actions update report**Priti Naik presented the report QC 22/2019 which provided an update on progress against the CQC ‘must do’ actions as well as against the three Trust-wide ‘should do’ actions. 15 actions had been completed and 4 out of 21 actions were delayed. She added that the Trust was also responding to the Provider Information Return request from the CQC. The meeting considered delivery against the ‘must’ actions for the Urgent Care service, noting that although the Urgent Care service strategy had been delayed it (and the strategy for the Community Hospitals inpatient service) was scheduled to be presented to the Board meeting in private on 24 May 2019. The meeting considered delivery against the ‘must’ actions for the Community Hospitals inpatient service and noted the new actions in progress (for completion by the end of June 2019) in relation to pain assessment and monitoring. In relation to the actions against storage of medicines at appropriate temperatures, the Chair asked about the estimated time of completion for installation of the air conditioning unit in the Didcot clinical room. Pete McGrane explained that the work required (including wiring and calibration) needed the air conditioning company as well as the Estates team but the Estates team were following this up. **The Committee noted the report.** *Priti Naik left the meeting*.  |  |
| **7.**abcd | **Draft Quality Account 2018/19**Jane Kershaw presented the draft annual Quality Account 2018/19 at paper QC 21/2019 and confirmed that this version had been circulated to external stakeholders (including commissioners, Healthwatch and Governors), as per requirements, for comment. Sula Wiltshire confirmed that commissioners had received this and that a joint Oxfordshire and Buckinghamshire response would be provided. Jane Kershaw reported that the Safety & Clinical Effectiveness Governors’ Sub-Group meeting on 02 May 2019 had considered the draft and suggested amendments to section 1.3 (local objective to improve the uptake and quality of annual staff appraisals) which would be updated. Governors had commented that as uptake of appraisals had increased markedly within the final month of the year, it may be more accurate to reflect that uptake may not have been as high as hoped throughout the year but that progress could still be demonstrated. The COO added that given the amount of supporting changes (and updates to the policy on appraisals) required, the Trust had not set out to demonstrate improvement month by month sustained throughout the year but once the policy had been amended and the online training record tool updated then it had become possible to improve provision of appraisals and supervision. Jane Kershaw highlighted the proposed Quality Improvement Plan for 2019/20 (at part 4 in the report from page 51). This proposed 14 key objectives against the quality domains of: patient and family experiences; patient safety; and clinical effectiveness. All objectives were aimed to be completed by 31 March 2020 with progress to be monitored on a quarterly basis by this Committee. The Chair commented positively upon the proposed objectives. **The Committee noted the report and, subject to the comments above on further amendments/updates to be made, supported the draft Quality Account 2018/19 including the Quality Improvement Plan for 2019/20.**  |  |
| **8.**abc | **Integrated Multi-Agency review report**Jane Kershaw presented the report QC 23/2019 which provided an overview of themes and learning across the following multi-agency external reviews which the Trust had participated in: Safeguarding Adult Reviews; Serious Case Reviews for children; Mental Health Homicide Reviews; and Domestic Homicide Reviews. If the Committee found this level of oversight to be useful then this was suggested as the first of a regular six-monthly report. It was noted that the detail in the report was confidential. The Committee commented that the report demonstrated the importance of taking a collaborative, not defensive, approach to reviews for the benefit of patients and overall learning. The Committee noted that in the future it may be useful to expand upon actions which could be taken, or which were being taken, in response to themes identified. **The Committee noted the report and that it would be worthwhile to start receiving these on a six monthly basis.**  |  |
| **9.**abcd | **Director of Infection Prevention & Control annual report 2018/19**Pete McGrane presented the report QC 24/2019 on progress in delivering the Infection Prevention & Control Programme and highlighted the achievements, as set out in the report. The Committee discussed the outbreak of Invasive Group A Streptococcus (**iGAS**) at section 8.3 in the report and noted that it would be useful to have more assurance about the findings of the multi-agency investigation led by Public Health England, or any lessons learned at a system level. Jane Kershaw confirmed that the learning identified by Public Health England had been shared across all relevant agencies, the Trust had developed its own action plan as a result; as set out in the report, actions had included screening of the whole district nursing team (including office staff and managers) and commencement of chemoprophylaxis for staff. All staff had screened negative. The Chair noted that he was less concerned about the Trust’s response and more concerned that other agencies had learned appropriately and been communicated with by Public Health England. However, it was acknowledged that the Trust had implemented appropriate learning. Pete McGrane confirmed that he had contacted patients, relatives and staff regarding the outbreak and that training had taken place with other district nursing team leaders to ensure that the rest of the service learned from the outbreak. Sula Wiltshire noted that she may be able to arrange a meeting between the Chair and Duncan Selbie, Chief Executive of Public Health England; the Chair noted that his interest lay in being assured that appropriate system learning had taken place after the iGAS outbreak. Aroop Mozumder asked about the Occupational Health team and the support it could provide, not only in relation to prophylaxis but also in relation to support for staff mental health as some staff may have felt under pressure and/or blamed following the iGAS outbreak. The MD noted that counselling was available through Occupational Health but the team did not have medics who could prescribe. Pete McGrane added that this was not unusual for an Occupational Health team. **The Committee approved the Infection Prevention & Control work which had taken place and RECOMMENDED the annual report to the Board for final approval.**  | **SW/****JAsb** |
| **10.**abcdef | **Monitoring the impact of waiting times for assessment and treatment in Mental Health Services**Pauline Scully presented the report QC 25/2019 which set out how the Trust managed patient safety whilst patients were waiting for assessment or treatment across Mental Health Services. She explained how this differed from performance reporting to the Board on waiting times against contractual targets. The report set out examples of services with waiting times and actions being taken to reduce risks to patients, including through risk assessment and monitoring of waiting lists. The report also recommended next steps, including the development of a clinical harm review process which should be aligned with work to improve data quality across the Trust and to enhance consistency in reporting and practice. The Chair thanked Pauline Scully for her concise but clear report which had highlighted the importance of improving consistency in approach and overview of the impact of waiting times. He noted that it would be relevant for this Committee to understand in future reporting: * which organisation/agency was responsible for people waiting for assessment or treatment;
* whether or at what point the Trust took responsibility for people who had not yet entered its services; and
* whether the Trust was managing patients it was not funded to treat.

The MD noted that there would be a distinction to be made between those people who were already engaged with services but awaiting further specialist intervention and those who may be waiting without existing contact. Sula Wiltshire welcomed the report as a useful start and emphasised the importance of understanding where patients were on a pathway of care and what clinicians’ expectations were. She asked if it would be helpful for her to share models of Equality Impact Assessments. Pauline Scully confirmed that she already had these and would be conducting these assessments. The CEO emphasised the importance of system ownership of the issue of waiting times, noting that this was not just a Trust responsibility or issue. He noted that the amount of information held at team level and not currently aggregated up was a symptom of the current focus at a local and national level upon contractual mechanics. Whilst service capacity was constrained due to underfunding and lack of resources, if attention was focused upon contractual waiting times targets and numbers going through the system then this gave a misleading impression that good access rates could equate to good care. The meeting discussed the challenge for primary care colleagues in dealing with demand from the local population. The Chair noted that not only was there work to do as recommended in the report to develop a clinical harm review process but also in relation to better understanding the situation in primary care. The DoS/CIO noted further work to be done to improve data quality so that the Trust could be clearer upon: access into services; the multiple care pathways which people could be on; and risks to people as they waited. **The Committee noted the report and that an update would be provided after 3 months’ (i.e. by the meeting in September 2019).** *Pauline Scully left the meeting*.  | **MC**  |
| **11.**abcd | **Pharmacy compliance report – compliance with Medicines Regulation** The Chair reminded the Committee of his declared interest as Clinical Director at Healthcare at Home Ltd which provided services to the pharmaceutical industry and into the NHS in the form of pharmaceutical-funded NHS services. Michael Marven presented the report QC 27/2019 which summarised the regulatory framework and requirements regarding medicines usage in the Trust from the: Medicines and Healthcare products Regulatory Agency (especially in relation to the Oxford Pharmacy Store (**OPS**)); Falsified Medicines Directive; Home Office; General Pharmaceutical Council; and the CQC. The CEO welcomed the report, noting that it was useful to provide a reporting line to a Board committee on quality aspects within OPS and the Pharmacy service. He noted that it could be developed further to examine how new quality governance arrangements were working. He suggested that the OHI Centre may also be able to contribute to the effective management of processes within OPS. Jill Bailey confirmed that the OHI Centre had already been in contact about this and a scholar from OPS was joining an OHI programme. **The Committee noted the report and that this would become a regular report.**   |  |
| **Escalation from quality sub-committees, directorates and risk registers** |
| **12.**abc | **Well Led quality sub-committee escalation report**The CEO presented the report QC 29/2019 and highlighted:* discussion of CQC engagement arrangements and follow-up on performance issues;
* the OHI Centre update; and
* discussion of mandatory training, PDRs (Personal Development Reviews/appraisals) and supervision which remained an area of concern.

He provided a further update that:* the CQC had confirmed that the Luther Street Practice would retain its rating of ‘outstanding’; and
* the Trust had achieved a Quality Mark accreditation for co-hosting of apprenticeships.

**The Committee noted the report**. *The CEO left the meeting*.  |  |
| **13.**ab | **Stroke Rehabilitation Unit**Pete McGrane provided an oral update further to investigation of concerns around behaviour which had been escalated from a Patient Advice & Liaison Service (**PALS**)session. The initial investigation had been completed and was being reviewed by the management team. The Chair requested a full report to the next meeting of this Committee in July 2019. **The Committee noted the oral update and that a report would be presented to the meeting on 10 July 2019.**  | **PMcG** |
| **14.**abc | **Caring & Responsive quality sub-committee annual report** The COO presented the report 28/2019 which provided an annual update of the business of the Caring & Responsive quality sub-committee. The report also recommended a division of responsibility into two committees to focus separately upon Caring and Responsive standards, as per the following proposed division of responsibilities:

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| **Caring to review:** * IWantGreatCare;
* Complaints/PALS;
* ICareYouCare;
* Equality & Diversity;
* Privacy & Dignity; and
* key thematic areas: Learning Disability Improvement Standards; End of Life Care; Delayed Transfers of Care; and Out of Area Placements.
 | **Responsive to review:*** Trust Strategy and Annual Plan to ensure meeting population needs;
* facilities and premises suitable for services;
* access standards and waiting times;
* appointments systems/single point of access; and
* technology to support timely access to care.
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Bernard Galton asked whether the bigger picture/issues around people could also be more explicitly included within the remit of one of the proposed new quality sub-committees. The COO agreed and noted that Staff Wellbeing could also be included under the remit of the Caring quality sub-committee. **Subject to the comments above, the Committee received the annual report and APPROVED the proposal to divest the responsibilities of the quality sub-committee into a new Caring quality sub-committee and a Responsive quality sub-committee.**  |  |
| **15.**ab | **Clinical Audit Plan 2019/20**The MD presented the report QC 26/2019 which set out the proposed Trust-wide Clinical Audit Plan 2019/20. He explained that this had been reduced as much as was safely possible and therefore what was presented represented high priority, ‘requires improvement’ or mandated national clinical audits. **The Committee APPROVED the Clinical Audit Plan 2019/20.**  |  |
| **16.**abc | **Effectiveness quality sub-committee escalation report** The MD presented the report QC 30/2019 and highlighted: * good progress made against the Clinical Audit Plan 2018/19, noting that the audit schedule for Q4 was on target;
* achievement of the target of 95% for Information Governance training by 30 March 2019. However, he expressed concern with the effort this had taken from the DoS/CIO and the Learning & Development team, noting that this would not be sustainable every year; and
* the update in the report on work to meet the NG17 Type 1 Diabetes Standards and PH38 Type 2 Diabetes Standards. A ink nurse role was also being developed so that a nurse in each ward/community team would have an additional element to their job description to liaise with the Specialist Diabetes Team around practice and education. Further to the departure of the Deputy Medical Director, a new Diabetes Steering Group would also be launched which would have a wider remit to consider all Trust services, including Mental Health.

The MD also provided a correction to the report on pages 9-10 in relation to the reference into the death of a patient from clozapine toxicity and the Coroner’s findings. The correction was that the Coroner had not made a recommendation for the Trust to review its clozapine guidelines; instead the Coroner had been positive about the care delivered and had noted that the Trust’s guidelines reflected national guidelines. Neil McLaughlin, who had represented the Trust at the inquest, confirmed that this was the case. **The Committee noted the report.**  |  |
| **17.**abc | **Safety quality sub-committee escalation report**Jane Kershaw presented the report QC 31/2019 and highlighted the following, noting that although mitigations had been discussed these were still issues for the Committee to be aware of:* training and skill gap for supporting patients with managing diabetes;
* delay from Oxfordshire County Council in holding strategy meetings and taking action following safeguarding referrals;
* new national targets to reduce gram negative blood stream infections was challenging for Community Services as this would require system-wide improvement work as the Trust was not solely responsible;
* work required to the seclusion room on Watling ward, given other priorities and limited capital funds;
* use of high cost agency staff to maintain safe staffing levels;
* fire risk on Wenrisk ward at Witney Community Hospital, for which controls and mitigations had been put in place; and
* reporting gap from the Medical Devices Group to the Safety quality sub-committee.

Sula Wiltshire requested a correction to page 1 of the report as it was not accurate that providers would no longer be invited to be members of children’s safeguarding boards or that representation would be through commissioners. She confirmed that locally this was not the case. Although there had been some statutory changes, locally the membership of the boards had stayed the same for adults and children’s safeguarding. **The Committee noted the report.**  |  |
| **18.**abcd | **Operational and Strategic risks discussion** The ATS introduced the paper QC 32/2019 on operational risks as set out in the Trust Risk Register (**TRR**) and strategic risks in the Board Assurance Framework (**BAF**), noting the description of the new demand and capacity risk being developed for the BAF at pages 3-4 in the report. Neil McLaughlin highlighted from the TRR:* the extreme risk added from the Community Risk Register on pain reassessment in community hospitals;
* the potential development of a new risk around the development of Liberty Protection Safeguards, which could replace Deprivation of Liberty Safeguards, and which was being discussed with the Head of Information Governance; and
* fire risk in Community Services, subject to discussion with the Senior Fire Safety Advisor to determine whether this should appear on the TRR or be held at local risk register level.

Neil McLaughlin noted that he was intending to return to reporting a snapshot of directorate risk registers in future reporting. **The Committee noted the report.**  |  |
| **Policy and Strategy updates** |
| **19.**ab | **Job Planning Policy for senior doctors within the Trust**The MD presented the new policy at paper QC 33/2019 and explained that the Trust had not previously had such a policy in place therefore the quality and standard of job planning for senior doctors had been variable across the Trust. **The Committee APPROVED the Job Planning Policy for senior doctors.**  |  |
| **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 20 February 2019 at paper QC 34/2019 and for the Buckinghamshire JMG from 07 February and 04 April 2019 at papers QC 35-36/2019. He highlighted the discussions around funding for Mental Health services and noted that demand and capacity issues remained live. **The Committee received the minutes.**  |  |
| **21.** a  | **Any Other Business** There being no further business to discuss, the meeting closed at: 12:43.**Date of next meeting: Wednesday 10 July 2019 09:00-12:30 in the POWIC Building, Warneford.** |  |

**Attendance 2019 - 2020**

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| **Members (quorum)** | **May 2019** | **July 2019** | **Sept 2019** | **Nov 2020** | **Feb 2020** |
| *Non Executive Directors (minimum 4 as members)* |
| Jonathan Asbridge  |  |  |  |  |  |
| Sue Dopson | *x* |  |  |  |  |
| Bernard Galton |  |  |  |  |  |
| Aroop Mozumder  |  |  |  |  |  |
| David Walker |  |  |  |  |  |
| *Executive Directors (Quality Committee membership includes the Executive Directors)* |
| Stuart Bell |  |  |  |  |  |
| Tim Boylin  | x |  |  |  |  |
| Marie Crofts | N/A |  |  |  |  |
| Mark Hancock  |  |  |  |  |  |
| Dominic Hardisty  |  |  | N/A | N/A | N/A |
| Mike McEnaney  | x |  |  |  |  |
| Debbie Richards | N/A | N/A |  |  |  |
| Kerry Rogers  | x |  |  |  |  |
| Martyn Ward | ✓ |  |  |  |  |
| **Regular Attendees** |  |  |  |  |  |
| Jill Bailey |  |  |  |  |  |
| Rob Bale |  |  |  |  |  |
| Rami El-Shirbini | *x* |  |  |  |  |
| Jane Kershaw |  |  |  |  |  |
| Vivek Khosla | *x* |  |  |  |  |
| Ros Mitchell | *✓* |  |  |  |  |
| Pete McGrane | *✓* |  |  |  |  |
| Neil McLaughlin | *✓* |  |  |  |  |
| Kirsten Prance | *x* |  |  |  |  |
| Kate Riddle | *x* |  |  |  |  |
| Hannah Smith |  |  |  |  |  |
|  |  |  |  |  |  |
| Sula Wiltshire | *✓* |  |  |  |  |

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)