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

**Quality Committee**

**BOD 36/2020**(Agenda item: 17(a))

**Minutes of a meeting held on**

**Wednesday, 12 February at 09:15**

**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 (**SB**) – *part meeting* |
| Marie Crofts | Chief Nurse (**MC**) |
| Bernard Galton | Non-Executive Director (**BG**) |
| Mark Hancock | Medical Director and Vice Chair of the Quality Committee (**MHa**) - *part meeting* |
| Mike McEnaney | Director of Finance (**DoF/MME)** - *part meeting* |
| Debbie Richards | Managing Director of Mental Health & Learning Disabilities (**DR**) |
| Kerry Rogers | Director of Corporate Affairs & Company Secretary (the **DoCA/KR**) - *part meeting* |
| 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**) |
| Jane Bell | Senior Quality Manager, Oxfordshire CCG (deputising for Sula Wiltshire, Director of Quality & Nursing Oxfordshire CCG) |
| Jo Faulkner | Head of Forensic Services |
| Rebecca Kelly | Associate Director of Allied Health Professionals |
| Vivek Khosla | Clinical Director - Buckinghamshire Mental Health Directorate) |
| Pete McGrane | Clinical Director - Community Services Directorate (**PMcG**) |
| Neil McLaughlin | Trust Solicitor & Risk Manager (**NMcL**) |
| Susan Parker | Dental Nurse Team Manager (deputising for Rosalind Mitchell, Clinical Director & Associate Medical Director - Dental Services) |
| Kirsten Prance | Associate Clinical Director - Learning Disabilities (**KP**) - *part meeting* |
| Hannah Smith | Assistant Trust Secretary (the **ATS/HS**) |
| Susan Wall | Corporate Governance Officer (Minutes) (**SMW**) |

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| **1.**  a  b | **Apologies for Absence**  Apologies for absence were received from the following Committee members (deputies of committee members count towards the quorum and attendance rates):   1. Tim Boylin, Director of HR 2. Aroop Mozumder, Non-Executive Director 3. David Walker, Trust Chair   Apologies for absence were noted from the following regular attendees:   1. Jilly Bailey, Associate Clinical Director, OHI 2. Rami El-Shirbiny, Clinical Director – Forensic Services (being deputised by Jo Faulkner, Head of Forensic Services) 3. Jane Kershaw, Head of Quality Governance 4. Kate Riddle, Deputy Director of Nursing 5. Sula Wiltshire, Director of Quality, Oxfordshire CCG (being deputised by Jane Bell, Senior Quality Manager, Oxfordshire CCG) 6. Claire Dalley, Director of Estates | **Action** |
| **2.**  a  b  c  d  e  f  g  h | **Minutes of the Quality Committee on 13 November 2019 and Matters Arising and Notes from the Away Day on 14 January 2020**  The Minutes at paper QC 01(i)/2020 were approved as a true and accurate record subject to amending the second sentence of item 3(f) in relation to pressure ulcer effectiveness to read “The Chief Nurse explained that it was an operational area which *could* be included in a quality dashboard or the Trust’s Online Business Intelligence (TOBI) tool but this was still subject to development”.  **The Committee noted the minutes.**  The Chair informed the Committee that paper QC 01(iii)/2020, Notes from the Quality Improvement Away Day 14 January 2020 would be incorporated into discussions to engender alternative ways of working at items 11, 12, 14, and 16 below.  ***Matters Arising***  **Item 2(b) from 13 November 2019 and 9(c) from 11 September 2019 – Resuscitation**  The Chief Nurse confirmed a draft review of resuscitation training had been completed by Helen Green, Director of Education and Development, and would be presented at the next Resus Committee. Requirements in relation to resuscitation equipment audits to be discussed at item 15.  **Item 2(c) and 16(c) – risks to amend on the Trust Risk Register**  Neil McLaughlin noted that this action had been partially completed but that the following remained to progress:   * Lowering the risk rating on TRR 1.19 (NRS Contract) - reduced from extreme to high in February 2020; * TRR 2.16 (visibility of waiting lists across services) - being put forward as a risk to be discussed at Oxon BSW and Bucks Mental Health DQG in February or March 2020 in completing development of risks; and * TRR 2.18 (CareNotes implementation/functionality in community hospitals: to be discussed at item 18 below.   **Item 12(b) – Disclosure and Barring Service (DBS) checks – delayed/outstanding**  It was confirmed DBS checks for new staff were taking place and the delay in DBS checks was linked to existing staff 3 yearly checks. The Committee confirmed this would be managed by the new People, Leadership and Culture (**PLC**)Committee with oversight by the Quality Committee through Bernard Galton’s joint membership of the PLC Committee (as PLC Committee Chair) and this Committee.  The Committee noted that the following actions were on hold to be progressed:   * 2(d) Stroke Rehabilitation Unit (closure of investigation) - deferred to the May Quality Committee due to staff sickness; * 17(c) Health Visiting Service: to schedule a presentation to include highlights and concerns; * 3(d) from 10 July 2019 – Clinical Audit update, especially in relation to physical health monitoring, on hold; and * 12(d) from 12 September 2018 - Complaints review panel – JAsb to attend a complaints Review Panel.   The Committee noted that the remaining actions from the Summary of Actions had been completed or were on the agenda for the meeting:   * 2(b) Resuscitation – Coroners letter from 13 November 2019 – Chair confirmed with Neil McLaughlin that if Coroners letter received highlighting resuscitation matters, it would be provided to the Committee; * 6(e ) Shared care patient records – Learning disabilities; * 7(c) Lone workers – device and software trial in January 2020 – The DoS/CIO confirmed action completed; * 7(d) HR representation at Quality Committee meetings – the Chair confirmed he had escalated this matter and it was noted that Bernard Galton was a joint member of both the PLC Committee and this Committee; * 8(c) Uploading of emails to patient records in CareNotes: action completed as can be done manually at present; * 9(b) Quality Account update; * 12(c) NHS Patient Strategy; and * 4(f) Quality Committee focused session/time-out on the theme of Quality Improvement.   *The CEO and the Director of Corporate Affairs & Company Secretary joined the meeting* | **NMcL** |
| **3.**  a  b  c  d | **Information Management Group highlight and escalation report**  The DoF reported on paper QC 02/2020 a summary of discussions held at the Information Management Group meeting 17 December 2019 where it was noted standard reporting was being managed efficiently.  The DoF highlighted areas for improvement being patient participation in care planning and care plans in general requiring more completeness of information from a governance perspective. He cited the transition of electronic records into community services impeding progress, however there was a team working to resolve the issues.  The Committee noted that staff training adherence is required to be at 95% by the 31 March 2020 and this is a level to be maintained on-going to demonstrate due diligence. It was stated that training could be passported from other trusts where appropriate.  **The Committee noted the report.** |  |
| **4.**  a  b | **Oxford Pharmacy Store (OPS) update on quality assurance**  The DoF gave an oral update to the Committee. He stated financial and commercial reporting was being directed to the Finance and Information Committee. He told the Committee that OPS was developing quality-focused reporting in line with Medicine and Healthcare Products Regulatory Agency (**MHRA**) and Good Distribution Practice (**GDP**) to cover pharmacy compliance and regulations. The DoF confirmed that this OPS quality reporting would be provided to the next Quality Committee meeting.  **The Committee noted the oral update.** | **MME** |
| **5.**  a  b  c  d  e  f  g  h | **Presentation from the Safety quality sub-committee and highlight and escalation report**  The Chief Nurse reported on paper QC 03(i)/2020, the Safety Quality Sub-Committee’s highlight and escalation report. She informed the Committee there had been twenty percent points increase in uptake of flu vaccine in frontline staff for this year. The Chief Nurse stated staff training for Infection Prevention & Control (**IPC**) was currently below the Trust target and had been identified as staff requiring to complete updates. This gap was currently being escalated for staff to complete updates.  The Chief Nurse informed the Committee a Health and Safety Executive (**HSE**) National Overview had taken place on a selection of NHS trusts. She stated areas highlighted from this report were being used to inform and undertake a gap analysis in health and safety in the Trust. She stated an update paper would be presented to the Executive at the end of February 2020 and then presented to the Quality Committee. The Managing Director of Mental Health & Learning Disabilities added that the HSE notice had also been considered by the Operational Management Team and would be cascaded to senior management teams and fed down into clinical areas. The Director of Corporate Affairs & Company Secretary added that the Board would also receive HSE training through a Board Seminar which was currently being scheduled, in liaison with Jane Kershaw and an external provider.  The Chief Nurse informed the Committee a workshop in collaboration with partners was being scheduled to operationally ensure the safety of staff in addressing issues of racial abuse, aggression and violence towards staff members.  The Chief Nurse highlighted some wards were overdue their 6 monthly fire drill, and in line with Fire Safety Inspections, this had been escalated to Service Directors for completion.  The Chief Nurse highlighted a safeguarding, “Must do,” from the 2019 CQC inspection of safeguarding for those working in seclusion and restrictive practices She added that a new Positive and Safe sub-committee had been set up to ensure standardised practice across the Trust and would incorporate new, Prevent Policy and legislation. She confirmed the Positive and Safe sub-committee would be triangulating information in generating any links between restrictive practices, sedation and patient health.  The Chief Nurse informed the Committee of the decision by the Safety sub-committee to discontinue the Mental Health Safety Thermometer Tool report as it was no longer useful in identifying risks and no longer relevant as all aspects of the safety thermometer were gathered in other reports and there was no national requirement to continue using the tool.  The Chief Nurse clarified for assurance to the Committee that all staff had safeguarding training, so the issue was overdue training not that they had not received any training. This was in relation to where the Trust was currently shown below target for Safeguarding Children Level 3. The below target figure referred to staff needing to complete refreshers and updates.  **The Committee noted the report.** | **MC** |
| **6.**  a  b  c | **National Patient Safety Strategy**  The Chief Nurse presented QC 03(iii)/2020 National Patient Safety Strategy Vision for the NHS to continually improve patient safety and the role of a safety culture to deliver it. She emphasised the vision being in improving patient safety through building a compassionate and kind culture comprising three key strategic objectives: Insight – improving understanding of safety; Involvement – Equipping patients and staff with the skills and opportunities in improving patient safety throughout the system, and Improvement – Design and support programmes in delivering effective and sustainable change in safety. She described it being a major change in focus moving to a systems and solutions approach with consultations being on-going.  The Committee discussed the shift from a Root Cause Analysis (**RCA**) approach to a more systems and solutions approach with the consensus of the Committee seeing the new approach being a positive move. The Committee noted the systems and solutions approach would bring new ways of looking at Serious Incidents (**SIs**), gathering and analysing information leading to new ways of thinking as a collective into investigations.  **The Committee noted the presentation.** |  |
| **7.**  a  b  c  d | **Safety of the Physical Estate report**  The Chief Nurse presented paper QC 03(ii)/2020 Safety of the Physical Estate report.  The Committee noted the significant improvement in reduction of risks from 2014 to 2019.  Kate Riddle enquired to know more about the, “extreme,” risk rating against seven projects and the Chair noted, in the absence of the Director of Estates being able to be at the meeting, an update be obtained from her on these items and to be circulated following the Committee.  **The Committee noted the report.** | **CD** |
| **8.**  a  b  c  d  e  f  g  h  i | **Oxfordshire, BaNES, Swindon and Wiltshire Mental Health Directorate – annual quality report**  Rob Bale reported on paper QC 04/2020, Annual Quality Report for Oxfordshire, BaNES, Swindon and Wiltshire Mental Health Directorate. He outlined that a key issue was attracting and retaining staff across all staff groups. He stated work was taking place with recruitment partners in improving targeting for specific roles and the approach applied.  Rob Bale reported the drive to reduce inappropriate Out of Area Placements (**OAPs**) had been successful with a reduction being seen together with the changes being embedded in the clinical arena.  Rob Bale informed the Committee the demand and capacity work across the Adult Mental Health Teams (**AMHT**) was nearing completion with draft findings identifying a 24% capacity gap. Findings were being benchmarked with solutions being sought, however these would be dependent on available resources.  Rob Bale stated challenges for Child and Adolescent Mental Health Services (**CAMHS**) continue with a rise in demand for services and that the on-going demand and capacity modelling was planned to be completed by March 2020.  Rob Bale highlighted to the Committee the challenges the Eating Disorder (**ED**) service was experiencing due to historic lack of investment in Adult Community ED services in the last five years in Oxfordshire. He stated there was a 4 month urgent referral wait for ED patients with these patients being of high clinical risk. The Managing Director of Mental Health and Learning Disabilities informed the Committee she had requested additional funding from the CCG for Q4 which had been declined. She stressed the compound effect of this on an already underfunded service added to clinical waiting times and poor staff morale. Rob Bale added a quality report was being undertaken in measuring a harm review risk in relation to extended waiting times. The Chair noted that this was already included on the Directorate Risk Register but stated that he would also escalate this to the Board for wider awareness. He also requested a more detailed report/update on the potential impact upon patient safety of the historic lack of investment in ED services in Oxfordshire, noting that this could be useful for the CCG/the CCG representative on this Committee to also consider.  *The CEO, Medical Director, and Director of Finance left the meeting. Kirsten Prance joined the meeting*.  The Chief Nurse sought reassurance before the new Crisis Resolution and Home Treatment Team (**CHRT**) went live that there would be adequate staffing levels so as not to rely heavily on agency staff. Rob Bale stated new staff were being recruited.  The Managing Director of Mental Health and Learning Disabilities enquired what oversight mechanism took place before new services/models were clinically signed off. The Committee discussed and confirmed the Clinical Advisory Board would provide governance.  The Chair gave recognition to the author, Natalie Cleveland, Head of Nursing, Oxfordshire, BANES, Swindon and Wiltshire Mental Health Directorate for an informative report and to Karen Lascelles, Nurse Consultant for the Adult Directorate Management Team for her continued diligence in work with the night team.  **The Committee noted the report.** | **RB/JAsb** |
| **9.**  a  b | **Oxfordshire Community Services Stroke Rehabilitation**  The presentation did not take place due to staff sickness.  **The Committee noted the report to be deferred to May Quality Committee.** |  |
| **10.**  a  b  c | **Care Quality Commission inspection/actions update report (Improving Care: 5 Questions highlight and escalation)**  The Chief Nurse reported on paper QC 05/2020 Improving Care: 5 (**IC5**) highlight and escalation report stating action plans had been completed and submitted to the CQC by 31 January 2020 on all issues identified in the CQC report.  The Chief Nurse stated a quality improvement approach was in place with issues being reviewed monthly at IC5 meetings with representatives from each Clinical Directorate and Corporate Services. Following the recent engagement day, the CQC were satisfied with the approach the Trust was taking in resolving issues.  **The Committee noted the report.** |  |
| **11.**  a  b  c  d  e  f  g  h | **Learning Disabilities & Autism – Healthcare access progress report**  Kirsten Prance reported on paper QC 06/2020 Healthcare access for people with learning disabilities and autism being a requirement for all trusts initiated by NHS Provider Improvement standards (**NHSI**).  Kirsten Prance highlighted the four standards required for reporting being: Respecting and protecting rights; Inclusion and engagement; Workforce, and Specialist learning disability services. The Chair noted people with learning disabilities and autism were featured in both the Trust’s Long Term Plan and in the BOB ICS plan that utilised the Improvement Provider Framework for structure.  The Managing Director of Mental Health and Learning Disabilities stated it was an informative report, however she felt there was insufficient information to ascertain how well the Trust was doing against actions together with a wider overview. Kirsten Prance replied it was challenging, as information and bench marking nationally were still being developed across the system for the data set. The Chief Nurse added her concern in how community services and mental health services were being monitored, as these services formed part of healthcare access as well as learning disability and autism. The Committee discussed how to progress quality assurance and agreed for the next Quality Committee that other Directorates should provide updates to cover compliance and adjustments made in relation to Learning Disabilities and Autism.  *The CEO joined the meeting.*  The Committee discussed the on-going historical issue of tracking and flagging people with learning disabilities on the Trust’s electronic system and across other systems. It was noted improvements to internal system services were required before cascading learnings out across services and areas. Kirsten Prance to meet with Vivek Khosla, Clinical Director, Buckinghamshire Mental Health Directorate to look at relationship to access.  The CEO provided an update further to his attendance at a SE Regional Meeting. He said potential risk had been considered in looking at Learning Disability and Autism as a separate category in relation to a high functioning person with Autism. In this scenario the person could experience a psychiatric admission and recover, this being a temporary scenario and one which is not being accounted for nationally. He added it was suggested there was evidence to suggest that a high proportion of young people, up to 70%, being assessed into CAMHS had autism in the background. The CEO stated both these factors presented challenges and may require changes in assessments, processes and care pathways.  Rob Bale informed the Committee there were challenges with limited commissioning across the area in funding for adults (over 18) in Learning Disabilities and Autism generating a commissioning gap in providing support in underfunded posts.  The Chair stated in the progression of quality assurance for the Committee for a paper to be submitted to the next Quality Committee on how effective the Trust’s care of people with Learning Disability or Autism was and to highlight how the Trust was responding to different needs and analysis of any gaps.  **The Committee noted the report.**  *Kirsten Prance left the meeting. The meeting took a break 10:52-11:00.* | **KP and clinical directors**  **KP/VK/**  **MW**  **KP/DR** |
| **12.**  a  b  c  d  e  f  g | **Quality Account objectives – update report**  The Chief Nurse reported on paper QC 07(i)-(ii)/2020, the Quality Improvement Plan for 2019/20 Quality Account objectives. She emphasised the importance of the Quality Account and Quality Indicators being an embedded part of the Trust’s quality approach and being mindful to work in collaboration with, rather than duplicate, objectives falling across other committees.  The Chief Nurse referenced a Trust-wide focus on staff psychological wellbeing and retention had recently commenced incorporating restorative just culture. She added detailed work was being undertaken on staff recruitment which would be filtered through to the new People, Culture and Leadership Committee.  The Chief Nurse stated the Carers and Family Strategy workplan was being revised to better recognise the needs of careers. This was a Trust-wide piece of work involving focus groups.  The Chair enquired if the Quality Account was required strategically. The Director of Corporate Affairs and Company Secretary confirmed the Quality Account formed part of the Trust’s Annual Report. The CEO added there was an ambition and drive across the BOB ICS in significantly reducing data collected, by 80%. He stated he was leading this work for the next few months and the focus would be establishing an integrated care system, to challenge duplication in order to streamline information to what is required.  The Chair reflected it would be important for the Trust to be as innovative as it could be with setting quality objectives for 2021 whilst keeping within reporting guidelines and taking onboard the information from the CEO in reducing data collection whilst maintaining a shared quality strategy in support of integrated care systems.  The Chair acknowledged the work of Jane Kershaw and others in producing the Quality Account.  **The Committee noted the report.** |  |
| **13.**  a  b | **Centre for Oxford Healthcare Improvement (OHI) progress report**  The Chief Nurse reported on paper QC 08/2020 Oxford Healthcare Improvement including: the capability building approach; projects; collaborations; project highlights, and governance.  **The Committee noted the report.** |  |
| **14.**  a  b  c  d  e  f  g  h  i  j  k | **Effectiveness sub-committee highlight and escalation report**  The Medical Director reported on paper QC 09/2020 Effectiveness highlight and escalation report. He stated clinical audits were positioned against plan for completion and on track for Q3.  The Medical Director highlighted positive achievements for staff health and wellbeing, notably: Employee assistance programme (**EAP**), being rolled out this week; positive feedback from roll out of pilot Schwartz programmes across the Trust with knowledge being gained and assimilated from the introduction of Consultant discussion groups on suicide being passed on to non-medical staff.  The Medical Director updated the Committee that 5 patients had been treated under a privately funded scheme with Esketamine a trial using a nasal spray in the treatment for depression, on a named patient basis. He stated the Trust would be putting together a business case for the CCG in preparation for when a UK licence is granted. Currently National Institute for Clinical Excellence (**NICE**) do not advocate recommendation due to cost.  The Medical Director informed the Committee the award from the National Institute for Health Research (**NIHR**) contract had received approval to be transferred from Oxford University Hospitals NHS FT (**OUH**) to Oxford Health NHS FT (**OH**).  The Medical Director spoke about the Trust-wide issue in achieving low audit ratings on Resuscitation Equipment in Q1-2. Pete McGrane informed the Committee the daily audits required by the Resus Council guidelines were: onerous; open to inaccuracy; created low staff morale and took 3.5 full time staff hours daily to complete this being a significant yearly cost to the Trust of approximately £170,000. The Trust was looking at ways to simplify the process across the 76 sites. The Chief Nurse confirmed she would be attending the next Resus Committee to review current processes and would report back to the Committee including on how other trusts were managing the checks.  The Medical Director stated a concern was raised from Q2 audit in pressure ulcer documentation requiring improvement in the District Nursing Service. Pete McGrane stated this was being investigated further via clinical leads and results would be reviewed at the next Quarterly Review Meeting (**QRM**).  The Medical Director spoke about the concern raised in compliance with guidance in Patient Group Direction (**PGD**) in the use of antimicrobials in Urgent Care. He stated the Drugs and Therapeutics Group (**DTG**) supported the current practice and training opportunities were being identified for non-medical prescribers.  The Medical Director informed the Committee the DTG supported the recommendation for the Trust use of Multi-Compartment Compliance Aids (**MCAs**), also known as blister packs, only in appropriate cases, as these systems thought previously to support patient compliance in taking medication, is now seen as a risk in terms of drug stability and therefore effectiveness, wastage and cost.  *The CEO and Vivek Khosla left the meeting*.  Referencing the Learning Advisory Group where low Personal Development Reviews (**PDRs**) were recorded for Corporate Services, Bernard Galton stated he would follow this up with the Director of HR.  The Assistant Trust Secretary raised a concern from the Audit Committee to the Quality Committee in relation to how clinical audits which were repeatedly ranked as ‘requires improvement’, or lower, were being followed-up and monitored for improvement. The Committee had a lengthy discussion on the National Clinical Audit of monitoring patients on lithium that had remained ranked as ‘requires improvement’. The Committee established patients’ lithium levels were monitored and recorded in primary care by GPs with no requirement for the blood test results to be sent on to secondary or specialist care. The Committee agreed contact to be made with the Lead GPs in Buckinghamshire and Oxfordshire to discuss lithium processes and for monitoring patients on lithium to be a special topic at the next Quality Committee meeting. The Committee may then be in a position to explore improving systems and safety.  **The Committee noted the report.** | **MC**  **MHa/DR** |
| **15.**  a  b  c  d | **Caring sub-committee highlight and escalation report**  The Chief Nurse reported on paper QC 10/2020 the Caring highlight and escalation report relating to experiences and involvement of people who use the Trust’s services. She highlighted the results of the National Community Mental Health Patient Survey for the Trust performance being in the top 20% nationally.  The Chief Nurse drew attention to the revised National guidance being implemented in January 2020 in the delivery of same-sex inpatient accommodation requirements being added to the Trust Risk Register as the CCG could impose a financial penalty for the possibility of a poor patient experience. The revised requirements were challenging to maintain and problematic for allowances required for the hospitalisation of transgender patients.  The Chief Nurse stated to the Committee it would be useful to review sub-committee structure and areas covered to alleviate duplication.  **The Committee noted the report.** |  |
| **16.**  a  b  c | **Responsive sub-committee highlight and escalation report – including updates from Section 75 partnerships Agreements/Joint Management Groups for Oxfordshire and Buckinghamshire**  The Managing Director of Mental Health and Learning Disabilities informed the Committee presented the report at QC 11/2020 and noted that this had followed the first meeting of the Responsive sub-committee. She stated it had been challenging to form Terms of Reference due to duplication across committees and to alleviate this sought formal consideration for: Equality, diversity and Inclusion (**EDI**) to report to the newly formed People, Culture and Leadership Committee; suggesting that Community Engagement Lead now only attend Caring sub-committee and a more thematic approach to agendas so colleagues were not required to write additional reports where there was no added value.  The Director of Corporate Services and Company Secretary reflected the original reasons behind separating Committees related to demand and capacity which had changed over recent times and agreed it was time to re-look at the sub-groups and reporting of sub-groups into main Committees. The Chair concurred and added this would be in line with discussions at the Quality Improvement Away Day in thinking of new ways of doing things. The Chair suggested an initial call with the Chief Nurse and the Director of Corporate Affairs & Company Secretary to discuss quality sub-committees, reporting lines and potentially revising terms of reference.  **The Committee noted the report.** | **JAsb/**  **MC/KR** |
| **17.**  a  b  c  d  e  f  g  h  i | **Operational and Strategic Risks from Trust Risk Register and Board Assurance Framework (including Risk Management Strategy Update)**  Neil McLaughlin reported on paper QC 12/2020 on operational and strategic risks: Trust Risk Register (TRR) and Board Assurance Framework (BAF) update. He bought to the Committee’s attention risk TRR 2.18 (CareNotes implementation/functionality in community hospitals). He stated much work had been undertaken in improving the electronic health record’s usability, involving Pete McGrane, since November 2019, however although progress had been made full assurance had not been gained so the risk remained active to progress.  Neil McLaughlin sought permission to attend the Caring and Response sub committees to present on TRR and BAF as he had already presented to Clinical Effectiveness and Safety. This was approved.  Neil McLaughlin informed the Committee that although he had hoped that migrating risk registers onto the system currently used by the Trust to log serious incidents would be straightforward, this had not been the case; having investigated this, he had concluded that there were some issues which the system could not overcome. He therefore recommended that a formal project, with project management support, be commenced this coming financial year to consider alternative options for hosting of risk registers as it would not be sustainable to continue with spreadsheets (but, as set out above, migration to the system currently used for logging serious incidents would not be straightforward either). Rebecca Kelly added that she had also tried expanding use of the system used for serious incidents into monitoring of NICE guidelines and had encountered similar difficulties. The Director of Strategy & CIO noted that there may be another product on the market which may be better than trying to make an existing system fit; or, there may be opportunities to look at management of risk at a BOB ICS system level. The Director of Corporate Affairs & Company Secretary confirmed that she and the Director of Strategy & CIO had already met and agreed some project management time/support to be made available for Neil McLaughlin and that this could allow the project brief and scope to be developed.  Neil McLaughlin confirmed that the Risk Management Strategy and Policy had been reviewed and was still fit for purpose, although within the next year it may benefit from updating to reflect changes in Board roles and committees.  Neil McLaughlin spoke about two new risks. Risk TRR 2.20 being breach of national updated guidance of same-sex inpatient accommodation and facilities arising from unexpected demand. The risk had been escalated to red and was being overseen via the Caring sub-committee and Chief Nurse.  Risk TRR 4.2 the potential loss of main dental and paediatric dental services contract through commissioning intentions of BOB ICS. Neil McLaughlin stated this had been escalated to a red rating and the CEO stated he would be raising his concerns to the Commissioners.  Following the Committee’s discussion of risk TRR 2.29 Housing OT it was established there was still a risk in the transfer of patients in the progression of the service transferring to Oxfordshire County Council (OCC) so the risk would remain on the register.  The Medical Director stated risk DQI 1.16 Scrutiny of admissions/detentions under the Mental Health Act (MHA) 1983 (section 15) was no longer relevant as there was a contact and back up associate medical directors available. Neil McLaughlin noted that he could review this.  **The Committee noted the report.** |  |
| **18.**  a | **Any other business**  None. |  |
|  | The meeting closed at 12.17  Date of next meeting 13 May 2020 09:00 – 12:20 in Room 1, Isis Centre, Warneford Hospital OX3 7JX |  |

1. Members of the Committee. The membership of the committee will include the executive directors and at least four 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. Deputies for the chairs of the quality sub-committees (the named vice chair of the sub-committee) will attend in an executive’s absence. Non-executive director members may also nominate a non-executive deputy to attend in their absence. [↑](#footnote-ref-1)
2. Regular non-member attendees and contributors. [↑](#footnote-ref-2)