

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

**Quality Committee**

**Minutes of a meeting held on**

**Wednesday, 13 November 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 (**SB**) |
| 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* |
| Aroop Mozumder | Non-Executive Director (**AM**) |
| Kate Riddle | Deputy Director of Nursing & Clinical Standards and deputising for the Managing Director of Mental Health & Learning Disabilities in their capacity as Chair of the Responsive quality sub-committee (**KRi**) |
| Kerry Rogers | Director of Corporate Affairs & Company Secretary (the **DoCA/KR**) |
| David Walker | Trust Chair (**DW**) |
| Martyn Ward | Director of Strategy & Chief Information Officer (the **DoS/CIO/MW**) |
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| **In attendance[[2]](#footnote-2):** |  |
| Jill Bailey | Associate Clinical Director – Oxford Healthcare Improvement Centre (**JB**) |
| Rob Bale | Clinical Director - Oxfordshire & BSW Mental Health Directorate (**RB**) (also deputising for Vivek Khosla, Clinical Director - Buckinghamshire Mental Health Directorate) - *part* *meeting* |
| Jane Kershaw | Head of Quality Governance (**JK**) |
| Pete McGrane | Clinical Director - Community Services Directorate (**PMcG**) - *part meeting* |
| Neil McLaughlin | Trust Solicitor & Risk Manager (**NMcL**) |
| Rosalind Mitchell | Clinical Director & Associate Medical Director - Dental Services (**RM**) |
| Kirsten Prance | Associate Clinical Director - Learning Disabilities (**KP**) |
| Hannah Smith | Assistant Trust Secretary (Minutes) (the **ATS/HS**) |
| Susan Wall | Corporate Governance Officer (Minutes) (**SMW**) |
| Helen Ward | Deputy Director of Quality, Oxfordshire CCG (**HW**), deputising for Sula Wiltshire |

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| **1.**  a  b | **Apologies for Absence**  Apologies for absence were received from the following Committee members (deputies count towards the quorum and attendance rates):   1. Tim Boylin, Director of HR 2. Mike McEnaney, Director of Finance 3. Debbie Richards, Managing Director of Mental Health & Learning Disabilities (deputised by Kate Riddle, Deputy Director of Nursing & Clinical Standards) 4. Sue Dopson, Non-Executive Director   Apologies for absence were noted from the following regular attendees:   1. Rami El-Shirbiny, Clinical Director – Forensic Services, Specialised Services Directorate 2. Vivek Khosla, Clinical Director, Buckinghamshire Mental health Directorate (deputised by Rob Bale, Clinical Director - Oxfordshire & BSW Mental Health Directorate) 3. Liz Williams, Service Director – Learning Disabilities, Specialised Services Directorate 4. Sula Wiltshire, Director of Quality, Oxfordshire CCG | **Action** |
| **2.**  a  b  c  d  e  f | **Minutes of the Quality Committee on 11 September 2019 and Matters Arising**  The Minutes at paper QC 60/2019 were approved as a true and accurate record.  ***Matters Arising***  **Item 9(c) from 11 September 2019 - Resuscitation**  Kate Riddle to update on resuscitation/resuscitation equipment audits and impact evaluation at next meeting (issues previously raised by staff had related to the amount of checking required in relation to such audits). Neil McLaughlin added that the Trust may receive a coroner’s letter highlighting resuscitation matters. The Chair requested that if the Trust received such a letter then this Committee should receive a copy of it, not just an update on it. Although he noted that the Effectiveness and Safety quality sub-committees may separately consider resuscitation, this Committee should be directly assured about resuscitation processes in mental health and community services.  **Item 14(a)-(b) from 11 September 2019 - 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) given recent mitigation from the Community Services Directorate; * developing the description of TRR 2.16 (visibility of waiting lists across services) as this may be more linked to mental health services and lowering the risk rating; and * reviewing TRR 2.18 (CareNotes implementation/functionality in community hospitals) as this may be able to be resolved fairly promptly (also discussed at item 16(c) below).   **Item 5(d) from 10 July 2019 - Stroke Rehabilitation Unit (closure of investigation)**  The Chair reminded the meeting that the Committee had been keen to meet the team and he invited them to report at the next QC meeting in February. Pete McGrane replied that this would be helpful and welcomed by the team; he noted that significant progress had been made and that the team had also presented at a national conference and had the potential to help to improve upon the Care Quality Commission’s ratings. The Trust Chair and the Chief Executive had also visited the team and commented positively upon the leadership.  The Committee noted that the following actions were on hold to be progressed:   * 3(d) from 10 July 2019 - Clinical Audit update in approx. 6 months’ Time/February 2020 – on hold; * 4(f) from 08 May 2019 - Quality Committee focused session/time-out on the theme of Quality Improvement – scheduled for 14 January 2020. The Chair emphasised the importance of moving towards becoming an improving organisation, not just reporting compliance; and * 12(d) from 12 September 2018 - Complaint 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(h) Transfer of Information Taskforce – the Director of Strategy & CIO confirmed representation on the group by a member of IT; * 8(j) Identification of people in the healthcare system with learning disabilities and autism – the Director of Strategy & CIO confirmed submission of a business case by 2nd December 2019; * 11(c) Responsive QSC membership – the Director of Strategy & CIO confirmed Strategy & Business Development representation on the group; * 14(a)-(b) risks amended on the Trust Risk Register:   + - lowering the risk rating on TRR 1.20 (Wantage Podiatry Fire Evacuation) given that the impact to the Trust as a whole may be lower than indicated; and     - removing TRR 2.17 (EMU discharge summaries) given investigation and swift mitigation of the situation. An element of the risk may continue on the Community Services Directorate risk register for local management but may not be required on the TRR; and * 17(a) Section 75 JMG reporting – on the agenda as part of paper QC 72/2019 (Responsive highlight and escalation reporting). | **KRi/MHa & NMcL**  **NMcL**  **PMcG** |
| **3.**  a  b  c  d  e  f  h  i | **Directorate Quality Reporting**  Pete McGrane Clinical Director, Community Services Directorate, reported to the Committee from QC 61/2019, Highlights of the Community Health Services Directorate Annual Report 2019.  The Chief Nurse enquired how “just culture” operated in practice with regards to falls. Pete McGrane advised clinical teams are aware of falls and trip hazard policies, however there were challenges around longer term care in how to understand longer term risks as a patient ages, or with changes in medication. An additional factor is a patient can receive multi-disciplinary care or is not under continuous care.  The Committee discussed community services and the Directorate’s position with ‘must’ and ‘should’ actions identified in NICE (National Institute for Health and Care Excellence) guidelines. It was noted that an overview of services may be useful to ensure greater oversight, scrutiny and highlight potential gaps in compliance with NICE guidance, with information being readily available for commissioning purposes (NICE guidance was part of the remit of the Effectiveness quality sub-committee and included in highlight and escalation reporting). The Chief Executive stated the Care Quality Commission (**CQC**) inspections do not inspect commissioning positions but have commented on the low level of investment into Trust Mental Health Services. He added CQC inspections would be moving to a more whole system review therefore a review of services with a formal gap analysis would inform the Trust of potential funding gaps, baselines and collaboratives in the breadth of services offered in preparation for the change.  The Trust Chair commended the report for demonstrating ‘closing the loop’ on actions but observed that it was inward focused although many services were delivered in partnership. He stated it would be useful for the community services report to have a wider feel to it as healthcare services developed towards population health management and provider collaboratives. Pete McGrane agreed this in principle but noted that the regulatory framework had not yet caught up with the way in which the Trust was operating in partnerships and that the inward focus was triggered by CQC also requiring a separate primary care report.  The Committee agreed the report contained interesting and useful information and the Chief Executive enquired how widely the report was shared. Pete McGrane advised it was possible to reach a wider audience by producing a user-friendly format.  The Director of Strategy & CIO and Aroop Mozumder queried how pressure ulcer effectiveness could be successfully measured and monitored. 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. Jane Kershaw noted that this was the first time that these themes and data had been brought together into one report. It was recognised that more narrative would be required to ensure the figures had more meaning.  The Chair highlighted that the reasons for CQC actions not being completed should be set out, for example in relation to the CQC action plan for community hospitals and medicines storage. Jane Kershaw replied that this may have just reflected the position as at March 2019. She noted that the only action which currently still required work related to air conditioning in Out Of hours at Banbury, which was subject to discussions with the landlord.  **The Committee noted the report.** |  |
| **4.**  a  b  c | **Care Quality Commission inspection/actions update report.**  The Chief Nurse reported to the Committee on paper QC 62/2019. She updated the Committee that the draft report of the CQC Well-led Inspection had been received by the Trust and was being checked for factual accuracy.  Kate Riddle stated the draft report showed improvement.  **The Committee noted the report.** |  |
| **5.**  a  b  c  d | **Integrated Multi-Agency Review report (including updates on Safeguarding, serious case reviews and homicide reviews)**  Jane Kershaw, Head of Quality Governance, reported to the Committee on paper QC 63/2019 Integrated Multi-Agency Review Report. The report brought together themes and learning from different external multi-agency reviews which the had Trust participated in: Safeguarding Adult Reviews, Serious Case Reviews for Children, Mental Health Homicide Reviews and Domestic Homicide Reviews.  Bernard Galton queried actions listed as “in progress” and how progress was being captured. Jane Kershaw explained the Trust was not necessarily the lead on actions as some services were multi-agency and clarifying steps were detailed in other reports.  Further to discussion, the Chair summarised the importance of ensuring that actions or recommendations for improvement were completed and challenges were known. For example, it was acknowledged that intra-agency communication could be a challenge but rather than just setting out aspirations to improve this, it would be helpful to set out what the Trust was doing about it and how it was progressing improvement. It was essential to capture what value the Trust was adding, how it was supporting teams and how to escalate both internally and externally. He emphasised the importance of moving from passive reporting towards actively engaging with what was happening and what could be done to pre-empt risks or issues.  **The Committee noted the report.** |  |
| **6.**  a  b  c  d  e  f  g  h  i  j  k  l | **Learning Disabilities & Autism – healthcare access progress report**  Kirsten Prance, Associate Clinical Director – Learning Disabilities, reported to the Committee on paper QC 64/2019 healthcare access for people with Learning Disabilities.  The Committee noted the report summary outlining the NHS Improvement (**NHSI**) Provider Implementation Standards detailing the nature of benchmarking and activity required to be undertaken in-line with national policies, programmes and standards. Kirsten Prance informed the Committee that feedback had been given to NHSI highlighting the challenge in merging prearranged different data sets for service users.  Kirsten Prance noted that, following an audit, improvements had been seen in utilising adjustments in mental health pathways. However, more understanding was required around the complexities and responsibilities within available resourcing.  Kirsten Prance stated a joint working project was ongoing with Oxford University Hospitals NHS FT (**OUH**)to support patients with complex health needs. Aroop Mozumder requested clarity on the process of a medical admission for a patient with complex health needs. Kirsten Prance said a register was held with a link to Learning Disabilities’ liaison nurses to support with care planning and review meetings which helped to ensure that mental capacity and capability were appropriately considered. This shared protocol service encompassed chronic health needs, catastrophic events, planning and care needs, end of life care planning and could lead to earlier discharge.  Kirsten Prance confirmed progress had been made with the tracking and flagging action plan, a national project ensuring reasonable adjustments were in line with timescales underpinning care pathways. She pointed out there were challenges in shared care patient records in: who had system access; system transparency; governance and training funds. The Chair cited the critical importance of shared care patient records and it was agreed for Kirsten Prance to meet with the Director of Strategy & CIO to discuss and progress the current challenges.  Kirsten Prance updated on anti-discriminatory practice and the Chair asked if anti-oppressive was included. Kirsten Prance confirmed that both anti-discriminatory and anti-oppressive were part of equality and diversity with everyone having equal rights and opportunities however the context of a client’s lived experience was taken into consideration in anti-oppressive.  The Chair appraised the level of information, scrutiny and learning from deaths in Learning Disabilities. It was noted deaths were in line with national mortality rates and some work was being done around a couple of gastro deaths which had been due to poor identification.  It was noted nationally all trusts must have the skills and capacity to meet the needs of people with Learning Disabilities, Autism or both by providing safe and sustainable staffing. Kirsten Prance said following the intake of the current nurses there was a gap of three years due to no funding provision. Plans were in progress for utilisation of funds for Learning Disabilities apprenticeships and Trust-wide training was planned to support staff to attain understanding and skills in Learning Disabilities.  In response to Rob Bale’s enquiry, Kirsten Prance explained it was difficult to compare the Trust with others as not all trusts provided Learning Disabilities services and it was more about sharing best practice than holding a position.  The Trust Chair noted that there was an opportunity and a gap to plug in order to raise the profile of Learning Disability and Autism services within local Buckinghamshire, Oxfordshire and Berkshire West (**BOB**) Integrated Care System (**ICS**) forums/meetings and nationally.  The Chair added it was a very useful report and gave support to further developments of the service.  **The Committee noted the report.**  *The Medical Director left the meeting* | **KP/MW** |
| **7.**  a  b  c  d  e | **Health, Safety & Security annual report**  Jane Kershaw reported on paper QC 65/2019 Health, Safety and Security Annual Report 2019 covering the period from 1st September 2018 to August 31st 2019 outlining the Trust’s health and safety arrangements to protect its employees, patients, contractors and members of the public. The report included slips and trips, manual handling, violence and aggression/challenging behaviour, lone working, work-related stress, hazardous substances (COSH), management of sharps, provision and use of work equipment including display screen equipment, first aid and working conditions.  The report had been considered by the Trust’s Health, Safety and Security Committee on 17th October 2019 and the Safety quality sub-committee on 29th October 2019. Key work from health inspections covered, compliance in display screen use, developing a resource handbook for managers to bring together key themes in one place, first aid training and a new policy for Zero Tolerance in relation to verbal and physical aggression.  On-going work included a review of the Trust’s Manual Handling policy, Sharps policy, Dietary (undergoing thematic review) and staff job descriptions. For lone workers, a device and software was planned for trialling in January 2020. The Director of Strategy & CIO acknowledged the importance of lone worker safety and requested a meeting with Jane Kershaw, Head of Quality Governance and Mark Walker, Head of IT, to ensure compatibility with existing systems supported in social care.  Bernard Galton raised the risk of a potential gap or duplication of some areas covered in this report with areas traditionally assigned to HR. This was discussed by the Committee and it was agreed the current lines of accountability were working. The Chair confirmed he would be writing to the Director of HR for an HR representative to attend future meetings.  **The Committee noted the report.** | **MW/JK**  **JAsb/ TB** |
| **8.**  a  b  c  d  e | **Inquests and Claims (Legal Services) annual report**  Neil McLaughlin reported on paper QC 66/2019 Inquests and Claims (Legal Services) annual report 2018/19 setting out details of claims, inquests and legal services activity for the period 1st April 2018 to 31st March 2019.  He highlighted themes arising from inquests in which the Trust had participated: communication with family and carers (consensual sharing of information), capacity and confidentiality, uploading of emails to patient-records and communication with other agencies.  The Committee discussed the uploading of emails to patient-records in the Trust’s CareNotes system.  It was agreed for the Director of Strategy and CIO, to review this process and report as to what may be the most efficient means by which migration of an email to clinical notes may be achieved.  The Chief Nurse asked if there was any learning to be gained from various coroners’ Prevention of Future Deaths reports issued across the wider NHS and other sectors. It was confirmed that Neil McLaughlin would report to the Weekly Review Meeting on any issues contained in reports issued to other organisations, as and when they arose, and which may be helpful for the Trust to know.  **The Committee noted the report.** | **MW** |
| **9.**  a  b  c  d  e | **Quality Account Objectives – 6 month update report**  Jane Kershaw reported on paper QC 67/2019 Update on Quality Improvement Plan 2019/20 (Quality Account Objectives). This 6-monthly report provided an update on achievement of quality objectives relating to quality domains such as patient safety, clinical effectiveness and patient/carer experience.  Jane Kershaw highlighted three areas proving more challenging to implement: developing workforce plans for each service, including resourcing, engagement and retention; improving the quality of care for a young person when they transition from child to adult mental health services; and actions to be identified for each acute ward to reduce violence and aggression from patients. The Committee noted the above three items and it was agreed these items be considered in more detail in the next report scheduled for the Quality Committee meeting in February 2020.  The Committee noted that the quality objectives for 2020/21 could potentially also be considered at the Quality Committee away day/focused session/time-out on the theme of Quality Improvement, scheduled for 14 January 2020  The Chair noted the regular absence of HR representation at these meetings was impacting the opportunity to discuss more fully.  **The Committee noted the report.** | **JK** |
| **10.**  a  b  c  d  e  f  g | **Centre for Oxford Healthcare Improvement progress report**  Jill Bailey presented the report QC 68/20219 on progress at the Oxford Healthcare Improvement (**OHI**) Centre, including capability building, projects, the development of collaborations, project management and governance.  Jill Bailey informed the Committee that the culture shift towards a continuously improving organisation had led to OHI receiving widespread requests for Quality Improvement (**QI**) project work and OHI was in the position of moving towards enabling others to lead QI in their areas with OHI support. She highlighted there were challenges around engagement in leadership for some projects and training was being planned. The Chair said it would be useful to have more evidence of the challenges, especially in relation to projects which might have started but then faltered due to disconnects or leadership issues, and for findings to be reported. He noted that the Quality Committee away day on the theme of Quality Improvement could provide an opportunity for the Committee to focus upon how to support management and the Executive to develop the culture of the organisation into one focused on improvement.  Jill Bailey cited the example of the ‘Failure to Return from Leave’ joint project with Thames Valley Police which was recommencing work in those areas that had not sustained the original interventions. A review would also take place as Thames Valley Police had changed their categorisation of risk and deployment of resources in relation to missing or AWOL persons since previously agreed risk matrices had been implemented jointly with the Trust. The Committee commented that this was an interesting example of multi-agency working and looked forward to receiving a further update in future reporting or potentially seeing this presented as a topic in more detail.  The Chief Nurse referred to the Evenlode Reducing Restrictive Practice project which had not been able to progress due to staffing issues. She expressed concern and noted that it would be necessary to refocus efforts on reducing restrictive practice not just on one ward but more widely across the Trust and to raise the status of reducing restrictive interventions.  The Chair referred to the section in the report on the development of collaborations and enquired if OHI projects received any funding from the BOB ICS. The Chief Nurse replied that this was not currently the case but, as set out in the report, an inaugural meeting had been held with transformation representatives from the BOB ICS and current activity was being mapped against the priorities for the ICS.  The Committee discussed safe practice at the Clinical Research Facility (**CRF**) which needed greater interface with general Trust services to prevent the CRF from becoming isolated from services and practices and procedures. The Chief Nurse explained that she had requested that the OHI team support the CRF with this. Aroop Mozumder expressed concern and asked for more detail. Jill Bailey explained that although the CRF had local procedures in place, these were too research-orientated and the existing systems could benefit from increased nursing and clinical governance guidance, especially if the CRF was going to engage in physical health procedures. The Chair noted that this could provide an exciting practice development challenge and perhaps a clinical secondment to support the CRF.  **The Committee noted the report.** |  |
| **11.**  a  b  c  d  e | **Effectiveness sub-committee highlight and escalation report**  Rob Bale on behalf of the Medical Director presented paper QC 69/2019, highlighting areas of compliance/good practice, as well as areas of potential concern, in relation to Clinical Audit, Learning & Development, Drugs & Therapeutics and Research & Development.  He reported general governance continued to function satisfactorily. However, in relation to Clinical Audit, three audited areas had been rated as ‘requiring improvement’ or lower but all had action plans and monitoring would continue to be included in future reporting:   * CPA (Care Programme Approach; * POMH (Prescribing Observatory for Mental Health - POMH-UK) Topic 6d: assessment of the side of effects of Depot Anti-Psychotics; and * NCAP (National Clinical Audit of Psychosis): Early Intervention in Psychosis Spotlight Audit#1.   In relation to Drugs & Therapeutics, he also highlighted: primary care mental health prescribing indicators in both Oxfordshire and Buckinghamshire; and Formulary and Shared Care in Buckinghamshire in particular where there had been some issues with prescribing arrangements in primary care not aligning with patient pathways (meetings in Buckinghamshire had taken place to address these issues).  He noted that the impact of the UK’s exit from the EU on the continuity of medicines supply was becoming an increasingly frequent question from staff, patients and carers. In response, there had been a communication to staff around the national plan to manage medicines supplies and confirmation that no local contingencies were required. The Chair asked where the Trust’s preparedness planning was reported. The Director of Corporate Affairs & Company Secretary confirmed that it was reported into the Executive prior to inclusion in the Chief Executive’s report to the Board.  **The Committee noted the report.** |  |
| **12.**  a  b  c  d  e | **Safety quality sub-committee highlight and escalation report**  The Chief Nurse reported on paper QC 70/2019 which set out that the Safety quality sub-committee had reviewed assurance and improvements in relation to: safeguarding adults and children; sexual safety thematic review; infection prevention and control; safety of premises; safe staffing; health, safety and security; fire safety; safe management of medicines (new area following revision of terms of reference); emergency planning; management and implementation of actions from national safety alerts; Quality Improvement projects being supported by the OHI Centre in relation to patient safety; reducing restrictive practice; enhanced observations to improve patients’ experiences and reduce self-harm; incidents, serious incidents and learning from deaths; safety thermometer audit; and restrictive practice.  Kate Riddle raised a concern around outstanding Disclosure and Barring Service (DBS) checks, noting the impact of HR staff shortage to undertake the checks. The Chair suggested that he raise this at the People, Culture & Leadership Committee.  The Chair requested that the new NHS Patient Strategy be considered for presentation at the next meeting.  The Assistant Trust Secretary reminded the meeting that a new Trust policy had been appended to the report for approval (the Blood Transfusion policy and procedures at CP 106), further to the recommendation of the Safety quality sub-committee. She reminded the Committee that it had a role to approve new clinical policies, in accordance with the Trust’s handbook for the production and management of policies at CORP 06. She noted that although this could have been presented to the meeting as a separate report with a covering sheet to set out the rationale for the new policy, its development process and any consultation/review it had been subject to, the Committee could seek that assurance in this meeting and choose to approve the draft presented. Kate Riddle and the Chief Nurse confirmed that it was useful for the Trust to have this new policy to ensure that correct blood/blood products were administered and that the policy was consistent with OUH practices. The Chief Nurse confirmed that the Safety quality sub-committee had recommended the new policy to the Quality Committee for approval.  **The Committee: (i) APPROVED the new Blood Transfusion policy and procedures at CP 106; and (ii) noted the highlight and escalation report.** | **JASb/BG**  **JK/MC** |
| **13.**  a  b  c  d | **Caring quality sub-committee highlight and escalation report**  Jane Kershaw presented paper QC 71/2019 and highlighted the work of the Caring quality sub-committee at its first meeting as separate sub-committee (having formerly been part of Caring & Responsive). The new Caring quality sub-committee received reporting from the following groups: the Taking Action from Patient Feedback group; the Carer and Family Forum; and various Complaint Review Panels.  She highlighted changes to the national guidance on delivering same sex inpatient accommodation.  The Chair commented that governors may be particularly interested in the work of this quality sub-committee in relation to patient and carer feedback and experiences. The Chief Nurse agreed and noted that she would also be delivering a presentation on patient and carer feedback to the next Council of Governors’ meeting in November 2019. The Trust Chair added that this would also be supported by a presentation from the Picker Institute on data collection analysis and the care and caution which would need to be given to the relative weighting of information about experiences from different sources and how this could be interpreted.  **The Committee noted the report.**  *Pete McGrane left the meeting.* |  |
| **14.**  a  b  c  d | **Responsive quality sub-committee highlight and escalation report**  Kate Riddle reported on paper QC 72/2019 and confirmed that this also summarised the work of the first meeting of the Responsive quality sub-committee. Terms of Reference had been agreed in line with CQC ‘Responsive’ key lines of enquiry. The new Responsive quality sub-committee received reporting from the following groups: Data Quality Group; Equality and Diversity Steering Group; Harm Review Group; Community Involvement Group; A&E Delivery Boards for Oxfordshire and Buckinghamshire; and the Section 75 Joint Management Groups (**JMGs**) for Oxfordshire and Buckinghamshire.  The report included summary reporting in relation to each of the Oxfordshire and Buckinghamshire JMGs  **The Committee noted the report.** |  |
| **15.**  a  b  c | **Well Led quality sub-committee highlight and escalation report**  The Chief Executive presented paper QC 73/2019 which summarised the work of the final meeting of the Well Led quality sub-committee. The scope of its business would primarily become the focus of the new People, Culture & Leadership Committee which would be a Board committee and provide direct assurance to the Board. However, other areas of focus such as Data Quality, Performance and Information Governance would be dealt with separately.  He highlighted:   * the Well Led quality sub-committee’s oversight of the Well Led Governance Development Plan and noted that next year would be three years’ on from the last Well Led governance review and that another would be due. He commented upon Board-level leadership changes since the previous Well Led governance review and noted that the review could be a useful self-assessment exercise; * since the final meeting, the Trust had received positive feedback from OFSTED about its inspection of the Trust’s apprenticeship provision and been found to be making satisfactory progress; and * the Trust’s new Supervision Lead had started in post.   **The Committee noted the report.** |  |
| **16.**  a  b  c  d | **Operational and Strategic Risks from Trust Risk Register and Board Assurance Framework**  Neil McLaughlin reported on paper QC72/2019 which set out operational risks from the Trust Risk Register (TRR) and strategic risks from the Board Assurance Framework (BAF).  The Committee discussed a new proposed red-rated risk escalated from the Community Directorate, at 2.19 in relation to OT service funding. The Committee noted that, Pete McGrane having now left the meeting (after item 13 above), it was not in a position to make a final decision on whether to accept the proposal to include this as a new risk at a Trust-wide level on the Trust Risk Register, or not. Neil McLaughlin took an action to discuss further with Chad Zuriekat, Senior Operations Governance Manager, and feedback to a future meeting.  The Committee did not consider that it could make a decision on the information presented.  The Committee discussed risk TRR 2.18 in relation to CareNotes implementation/functionality in Community hospitals (as also subject to action under item 2(c) above).  The Community Services Directorate had considered that it should remain on the TRR, but Information Management & Technology team had taken a different position. Further to the action already set out at item 2(d) above, it was confirmed that Neil McLaughlin would discuss with the Director of Strategy & CIO to determine whether TRR 2.18 should remain on the TRR.  **The Committee noted the report.** | **NMcL** |
| **17.**  a  b  c  d | **Carers’ Strategy (‘ICareYouCare’) – annual family, friends and carers’ progress report.**  Kate Riddle presented the paper QC 75/2019 which set out the draft Annual Family, Friends and Carers’ Report 2018/9.  It was noted work had started on identifying development areas for the next strategy as the ICareYouCare strategy was in its third and final year, ending in June 2020.  The Chair mentioned it had been sometime since an update had been received from the health visiting service. Jane Kershaw stated she would consider, with Pete McGrane, the possibility of arranging a presentation or providing a paper for a future meeting.  **The Committee APPROVED the draft Annual Family, Friends and Carers’ Report for publication.** | **JK/PMcG** |
| **18.**  a  b  c | **Section 75 Joint Management Groups (JMGs)**  Kate Riddle informed the Committee that an update on JMGs had been included in the Responsive quality sub-committee’s highlight and escalation report at paper QC 76/2019, item 14 above.  The Committee discussed the value of Section 75 JMGs being reported to this Committee (which was also a requirement under this Committee’s Terms of Reference as well as under the Section 75 agreements). The Chief Executive noted that reporting into this Committee (at Board Committee level) remained appropriate, especially considering the changing nature of the relationships in health and social care, funding challenges and this Committee’s oversight of quality, sustainability and operational matters.  **The Committee noted the report.** |  |
| **19.**  a  b | **Any Other Business**  The Chief Nurse informed the Committee that the flu vaccination programme had been impacted by delays in the national supply chain but progress was still on track and the focus was on front-line patient-facing staff. The Board would separately receive a report on the flu vaccination programme at its meeting in December 2019.  The Committee noted that Priti Naik, Lead for Quality & CQC Standards, would be leaving for another post and thanked her for work, noting her contribution to the regular reporting presented to this Committee on CQC actions. |  |
|  | The meeting closed at 11.59  **Date of the next meeting: 14 January 2020 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 2019** | **Feb 2020** |
| *Non Executive Directors (minimum 4 as members)* | | | | | |
| Jonathan Asbridge |  | *✓* | *x* | *✓* |  |
| Sue Dopson | *x* | *x* | *x* | *x* |  |
| Bernard Galton |  | *✓* | *✓* | *✓* |  |
| Aroop Mozumder |  | *x* | *✓* | *✓* | *x* |
| David Walker |  | *x* | *✓* | *✓* | *x* |
| *Executive Directors (Quality Committee membership includes the Executive Directors)* | | | | | |
| Stuart Bell |  | *✓* | *x* | *✓* |  |
| Tim Boylin | x | *x* | *x* | *x* | *x* |
| Marie Crofts | N/A | *✓* | *✓* | *✓* |  |
| Mark Hancock |  | *✓* | *✓* | *✓* |  |
| Dominic Hardisty |  | *✓* | N/A | N/A | N/A |
| Mike McEnaney | x | *x* | *x* | *x* |  |
| Debbie Richards | N/A | N/A | *✓* | *Deputised* |  |
| Kerry Rogers | x | *✓* | *✓* | *✓* |  |
| Martyn Ward | ✓ | *✓* | *✓* | *✓* |  |
| **Regular Attendees (non-voting)** | | | | | |
| Jill Bailey |  | *✓* | *x* | *✓* | *x* |
| Rob Bale |  | *x* | *✓* | *✓* |  |
| Rami El-Shirbini | *x* | *x* | *x* | *x* | *Deputised* |
| Jane Kershaw |  | *x* | *✓* | *✓* | *x* |
| Vivek Khosla | *x* | *✓* | *✓* | *Deputised* |  |
| Ros Mitchell | *✓* | *✓* | *Deputised* | *✓* | *Deputised* |
| Pete McGrane | *✓* | *✓* | *✓* | *✓* |  |
| Neil McLaughlin | *✓* | *x* | *x* | *✓* |  |
| Kirsten Prance | *x* | *✓* | *Deputised* | *✓* |  |
| Kate Riddle | *x* | *x* | *✓* | *✓* |  |
| Hannah Smith |  | *✓* | *✓* | *✓* |  |
| **Oxfordshire CCG (observer/non-voting)** | | | | | |
| Sula Wiltshire | *✓* | *✓* | *✓* | *Deputised* |  |

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)