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

**Quality Committee**

**QC 44(i)/2021**(Agenda item: 02)

**Minutes of a meeting held on**

**Thursday, 09 September 2021 at 09:01**

**via virtual Microsoft Teams meeting**

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| **Present[[1]](#footnote-2):** |  |
| Aroop Mozumder | Non-Executive Director (**AM**) (the Chair) |
| Nick Broughton | Chief Executive Officer (**CEO/NB)** - *part meeting* |
| Marie Crofts | Chief Nurse (**CN/MC**) |
| Karl Marlowe | Chief Medical Officer (**CMO/KM**) - *part meeting* |
| Debbie Richards | Executive Managing Director for Mental Health and Learning Disability & Autism Services (**DR**) |
| Ben Riley | Executive Managing Director for Primary and Community Services (**BR**) |
| Kerry Rogers | Director of Corporate Affairs & Company Secretary (the **DoCA/CS/KR**) |
| Martyn Ward | Director of Strategy & Chief Information Officer (the **DoS/CIO/MW**) |
| **In attendance[[2]](#footnote-3):** |  |
| Katrina Anderson | Service Director Oxon & BSW Mental Health – Deputising for Rob Bale, Clinical Director – Oxfordshire & BSW Mental Health Directorate (**KA**) - *part meeting* |
| Jo Faulkner | Head of Forensic Services, Deputising for Rami El-Shirbiny Clinical Director, Forensic Services) (**JF**) - *part meeting* |
| Angie Fletcher | Head of Quality Improvement (**AF**) |
| Jane Kershaw | Head of Quality Governance (**JK**) |
| Vivek Khosla | Clinical Director – Buckinghamshire Mental Health Directorate (**VK**) |
| Pete McGrane | Clinical Director, Community Services (**PMcG**) |
| Ros Mitchell | Clinical Director & Associate Medical Director, Dental Services (**RM**) |
| Neil McLaughlin | Trust Solicitor and Risk Manager (**NMcL**) |
| Peter Milliken | Deputy Director of Finance (**PM**) |
| Marco Pontecorvi | Oxford Health Biomedical Research Centre Manager (**MP**) |
| Kirsten Prance | Associate Clinical Director, Learning Disabilities (**KP**) |
| Sarah Putman | Staff Nurse, Ruby Ward (**SP**) - *part meeting* |
| Michaela Saunders | Interim Ward Manager, Sapphire Ward (**MS**) - *part meeting* |
| Susan Wall | Corporate Governance Officer (Minutes) (**SW**) |
| Helen Ward | Head of Quality, OCCG representative (**HW**) |
| Hannah Wright | Risk Manager (**HWr**) |
| **Observers:** | |
| Julia Marren | Infection Prevention and Control Nurse |

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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. Bernard Galton, Non-Executive Director 2. Mike McEnaney, Director of Finance 3. David Walker, Trust Chair   Apologies for absence were noted from the following regular attendees:   1. Rob Bale, Clinical Director – Oxfordshire & BSW Mental Health Directorate – Deputised by Katrina Anderson, Service Director Oxon & BSW Mental Health 2. Rami El-Shirbiny, Clinical Director – Forensic Services - Deputised by Jo Faulkner, Head of Forensic Services 3. John Geddes Professor of Psychiatry 4. Britta Klinck, Deputy Chief Nurse 5. Hannah Smith, Assistant Trust Secretary 6. Bill Tiplady, Consultant Clinical Psychologist and Associate Director of Psychological Therapies | **Action** |
| **2.**  a  b  c  d | **Minutes of the Quality Committee on 08 July 2021 and Matters Arising**  The Chair welcomed all those present and informed the Committee this would be his last Chairing of the Quality Committee as he would be retiring from the Trust at the end of the month.  The Minutes at QC 32/2021, Minutes of the Quality Committee (**QC**) on 08 July 2021 were approved as a true and accurate record.  **The Committee approved the minutes from 08 July 2021.**  ***Matters Arising***  The Committee noted the action from the Summary of Actions was on the agenda for the meeting:   * 12(d) Waiting list times. |  |
| **SAFETY** | | |
| **3.**  a  b  c  d  e  f  g  h | **COVID-19 Update**    The Chief Nurse commenced the Covid-19 oral update stating that since the July QC the Trust had had a total of five Covid-19 positive patients in inpatient settings, of which one case had been community acquired being detected on admission. She mentioned at a recent Regional Infection Prevention Control meeting it had been noted that Covid-19 cases were increasing in community settings in both Buckinghamshire and Oxfordshire and that this was increasing pressure on the system.  The Chief Nurse confirmed approximately 80% of front-line staff had received their first vaccination and that on-going support and advice was available for staff to address queries. She stated there had been no change in infection prevention control measures in NHS hospitals and community settings although there had been relaxation in control measures in the public arena over recent months.  The Director of Strategy and Chief Information Officer presented the live Covid-19 dashboard showing trends for Covid-19 cases for the Trust over the previous months. The Trust currently had one Covid-19 positive inpatient, and the position on Covid-19 cases were reviewed regularly at Infection Prevention Control meetings. He highlighted there were still inaccuracies that were being addressed in the recording of staff vaccine uptake data on the Trust’s system. He noted there were 246 staff across the Trust who were medically exempt from having the vaccine and of these 194 were patient facing roles. Line-managers were continuing the process of liaising with all staff regarding vaccination uptake and assisting with queries. There were a small number of staff, approximately 10%, who remained and were in the process of being contacted. This group included flexible agency workers who were available for work but may not have worked for a while, and junior doctors who may have moved on from the Trust. He said there was further work to be done to confirm the Trust’s Covid-19 vaccination position.  The Chair enquired about the Trust’s position regarding recent considerations for the Covid-19 vaccination to be compulsory for NHS frontline staff. The Chief Executive stated the Trust’s position would always be to follow national policy. The Chief Nurse added from mid to late November 2021 it would become mandatory for staff going into Care Quality Commission (**CQC**) registered care providers/places of residence to be double vaccinated and planning ahead for this would need to be considered.  The Committee discussed data quality issues in the recording of vaccination data for the Trust, and the impact of workforce capacity and service provision owing to Covid-19 staff absences, noting this position had improved significantly.  The Chief Nurse informed the Committee planning for the flu vaccination campaign was underway with the first delivery of vaccinations being expected at the end of September. Weekly flu update meetings had commenced and there were two full time staff from the Trust who would be dedicated in rolling out the flu vaccination programme. She said there were 40 flu vaccinators across the Trust’s geography to assist in the roll out of the vaccination programme.  The Chief Nurse stated staff in mass vaccination centres were now included in the flu campaign so this would increase the baseline figure. She said she had written to the Regional Chief Nurse for clarification for flu vaccination uptake for temporary and bank staff. She noted the response would likely inform and potentially change the position for the recording for Covid-19 vaccination for those who were temporary and/or bank staff.  **The Committee noted the oral update.**  *Jo Faulkner joined the Committee.* |  |
| **4.**  a  b  c  d  e  f  g  h  i | **Quality and Clinical Governance Sub-Committee Escalation Report**  The Chief Nurse presented paper QC 33/2021 Quality and Clinical Governance Sub-Committee (**QCG-SC**) Escalation Report. She highlighted the report comprised of the last two months of reporting to the QCG-SC and pointed out the paper showed the breadth of topics covered. The QCG-SC was an opportunity for Directorates to undertake a deep dive into their Directorate Service to enable: sharing of best practice; sharing of concerns; any impact on services; consideration of any relevant mitigations; and escalation of issues if required. She stated some services were currently in business continuity status, although this increased pressure would continue for some time she highlighted that any clinical concerns were reviewed at the Weekly Review Meeting (**WRM**).  The Chief Nurse informed the Committee there was an on-going national shortage of Speech and Language Therapists, and that there had been no success in recruiting to date via advertising, and that recruiting for other Allied Health Professionals (**AHPs**) groups was proving challenging also. She stated the Trust’s Associate Director of AHPs was currently on secondment to NHS England (**NHSE**), and the AHP Lead, Mental Health Services and the AHP Lead, Community Hospitals were covering for this period.  The Chief Nurse informed an appointment had been made for the role of Senior Resuscitation Officer, and a priority responsibility would be embedding the changes in resuscitation training.  The Chair requested an update on three areas covered in the paper these being: staffing challenges in community services; social care provision for discharged patients; and oversight and learning from deaths. The Chief Nurse said there would be further details in response to these areas in the next item the Quality and Safety Dashboard. She outlined the WRM remit where services were reviewed on-going was followed by the Operational Management Team (**OMT**) meeting which was attended by relevant Executive Directors, Clinical Directors and Service Directors. The weekly WRM and OMT meetings offered timely opportunity to discuss issues and be proactive in putting in place mitigation plans if required. She stated that for services experiencing challenges all had individualised business continuity plans in place.  The Executive Managing Director for Mental Health and Learning Disability & Autism Services stated mental health services for: Oxford; Banes, Swindon, and Wiltshire and Child and Adolescent Mental Health Services (**CAMHS**), Melksham all had business continuity plans in place. This was in part due to historic underfunding, lack of workforce, and post Covid-19 surge in referrals. Although additional investment had been received for services the issue in recruiting new staff towards an established workforce would take time. She stated, as the Chief Nurse had, that all teams were monitored weekly, and gave assurance that emergency and urgent referrals were being picked up. She noted an area of sensitivity at the moment was the impact of waiting times for routine referrals.  The Executive Managing Director for Primary and Community Services stated the District Nursing Service (**DNS**) was currently understaffed and that this was generating pressure in meeting the demand in services, with many planned visits requiring to be ‘rolled over’ into the following day. The DNS was employing the Quality Impact Assessment approach to prioritise activity and were considering alternative working approaches. A current short-term trial was the provision of taxis for District Nurses who worked in Oxford City with the aim for it to be less stressful and to fit in more visits. Longer-term recruitment plans were being developed. The Clinical Director, Community Services added the situation of understaffing by long standing vacancies, had been compounded by sickness through stress in the District Nursing Team. He said the District Nursing Team had also been impacted by historical under investment. He noted demand for services had increased together with increased acuity and dependence being seen, leading to patients requiring longer and more frequent appointments. He stated from the previous day 186 appointments had been rolled over, 42 of these had been attributed to phlebotomy and the availability of blood bottles, however the average roll over of appointments currently was approximately 170 per day. He said the rolling over of appointments was being proactively managed and monitored closely by senior clinical managers and was being reviewed at the WRM and OMT.  The Chief Executive expressed there were many challenges and teams were working hard and it was essential to support staff well-being to avoid burn out. It would be key for leaders to allow teams to be given time to have a session together to reflect, think creatively, and work together in finding solutions to challenges.  The Chief Medical Officer gave an update on the oversight and learning from deaths. He referred to the paper presented at the last Quality Committee in July 2021 that outlined the governance structure and alignment of mortality with incidents. He said a gap analysis was underway and the Mortality Review Group Terms of Reference would be updated accordingly. He said it would be important for consideration for a Non-Executive Director to be part of the group.  **The Committee noted the report.** |  |
| **5.**  a  b  c  d  e | **Quality and Safety Dashboard**  The Chief Nurse presented paper QC 34/2021, Quality and Safety Dashboard outlining the report offered an ‘at a glance view’ of performance for all clinical services across the Trust, both for inpatient and community and covered a range of quality measures and indicators from the domains of safe, effective, and caring. The report was work in progress and had been further developed since being first presented at the last Quality Committee in July 2021. In time it would support trends for a rolling 12-month period.  The Chief Nurse stated that all Service and Directorate Management Teams had access to the safety and quality dashboard via the Trust’s inhouse (**TOBI**) system which would enable teams to see where any hot spots were and would support proactive management of any concerns. The dashboard was a useful tool for cross referencing issues and concerns at the WRM and if a ‘deep dive’ was required for more in-depth reporting and review at the QCG-SC.  The Chief Nurse said the report provided detail around ‘fill rates’ that were required to be reported to the Board, and also included agency usage. She mentioned work had been delayed in the pursuit of reducing agency spend as the Director of Clinical Workforce and Transformation had been involved in supporting the setup of mass vaccination clinics and the roll out of the vaccine programme, however work on reducing agency was now back on track. The Chief Medical Officer added it was important to cover the quality issue of the impact of vacancies and high agency usage, and it would be beneficial to have sight of staff turnover rates and absences in the dashboard as this was relevant for both the QC and the Board Sub-Committee, People, Leadership and Culture Committee.  *Karl Marlow left the meeting.*    The Chair enquired about the below levels of supervision taking place. The Chief Nurse assured the Chair that supervision was taking place and was being monitored, however there had been a system issue in recording supervision on the portal that had now been resolved.  **The Committee noted the report.** |  |
| **6.**  a  b  c  d  e | **Learning from Serious Incidents**  The Chief Nurse presented paper QC 35/2021, Serious Incidents (**SIs**) Q1 Update, and that future reporting would be in alignment with quarters to support review. She highlighted in Q1 22 SIs had been reported onto the national transfer of Strategic Executive Information System (**StEIS**) and that this figure excluded all incidents that had been downgraded by the commissioner.  There were a number of key themes that had been identified with two main issues being identified for additional focus as Quality Improvement (**QI**) projects, these being: Communication and involvement of family members during care; and Risk formulation/documentation. The QI projects were being led by Clinical Directors, supported with corporate nursing and clinical governance and were in the diagnostic stage.  The Chief Nurse reported there had been positive feedback received on the new process of reporting SIs that was being embedded in the Trust. Part of the new process to support teams had been the introduction of a ‘safety huddle’ within 48-72 hours of an incident to review and determine if a root cause analysis would be required or an after-action review. Additionally, there was a new Patient Safety strategy that required two patient specialist partner roles that would need to be adopted.  The Chief Executive enquired about the high number of domestic homicide reviews. The Chief Nurse stated there were no known relationships between the recorded numbers and increase in domestic violence being recorded owing to the pandemic. She added all incidents were being recorded via Individual Management Reports and were led by an Executive or Clinical Director.  **The Committee noted the report.** |  |
| **7.**  a  b  c  d  e  f  g | **Learning Disabilities & Autism – access to healthcare annual report**  The Associate Clinical Director, Learning Disabilities presented Paper QC 36/2021, Progress Report on The Learning Disability Improvement Standards. She highlighted the paper was an annual report to show the Trust was compliant in its statutory and regulatory duties in that services offered were adapted to the needs of those with a Learning Disability (**LD**) or Autism in support of access to required healthcare. It was noted the complete benchmarking report had yet to be received from the NHS and on receipt an updated report would be presented to the QCG-SC.  Points noted from the paper:   * Digital flag project – for easier identification to flag and track those with LD or Autism on electronic clinical records. Due to challenges across different electronic systems the pilot had been suspended and progress was being followed up. * Review of deaths – LD reporting was in line with the Learning from Deaths of People with a Learning Disability (**LeDeR**) system, and in line with the Integrated Care System developments. Oxford Health was leading work to include Autism. * Rapid reviews – had been undertaken for where Covid-19 may have been an indicator. * System Action Plan – obesity index had been identified as being significantly higher in those with LD and Autism and a system health care plan was being actioned. * End of care – progress towards preventative care was on-going. * Hospital admissions – these had been low owing to the work and support by the Reasonable Adjustment Team (**RAS**). * Co-production – had been included as part of a Leading Together initiative and this area was progressing. * Care planning – a range of person-centred tools were available to support teams working with those with LD and Autism. * Staff training and workshops – had been taking place and formed part of all staff training matrixes.   The Chair enquired about progress of physical healthcare assessments for those with LD and Autism. The Associate Clinical Director replied that as a system the position was robust and further progress would be ensuring effective partnership working with GPs to ensure health action plans were put in place as required.  The Chief Executive enquired how the Community Mental Health Teams were responding to increased referrals from those with LA and/or Autism. The Associate Clinical Director replied the RAS team were working hard to ensure supporting information was available and accessible via the website and other formats. The team were working closely with Mental Health Teams to identify issues early in order to provide adjusted pathways, and there could potentially be a peak in the next 3 – 6 months as people adjusted to changing environments arising from the pandemic.  The Executive Managing Director for Mental Health and Learning Disability & Autism Services highlighted there was an increase in disordered eating in young adults and that a system pathway for escalation would benefit these people as incidence of Autism was high in this cohort, and it would be important to work with families to optimise solutions. She highlighted that on the National Matrix Oxford Health performed very well on LeDeR reviews, annual health checks, and low use of beds in keeping those experiencing a crisis in the community. She was positive about future initiatives and collaborative working with community partners and social care commissioning in resourcing alternative community-based pathways for care. She commended the Associate Clinical Director and the team’s achievements as a small group of specialists in spite of the challenges that had been presented in team members being lost owing to stress.  The Clinical Director, Buckinghamshire Mental Health Directorate added there were differences in the service in Buckinghamshire as they did not have an RAS team, and it was at times challenging to meet expectations from families in very complex and difficult cases. He added Buckinghamshire were providing a short-term psychological course on complex patients that would assist in supporting patients with challenges.  **The Committee noted the report.** |  |
| **Effectiveness** | | |
| **8.**  a  b  c  d  e  f  g  h | **Clinical impact of waiting times**  The Director of Strategy and Chief Information Officer presented papers at QC 37/2021: Operational Escalations Report – Waits Summary 31 August 2021; Focus on Patient Waits Report – Emergency and Urgent referrals; Operational Escalations Report – Waits Summary 31 August 2021; and Operational Escalations Report and latest Mental Health Long Term Plan performance.  The Director of Strategy and Chief Information Officer stated a summary report of waiting times was presented weekly at OMT meetings for review by senior leaders and was available to teams.  *Michaela Saunders joined the meeting.*  He outlined the initial focus on waiting times had been for those waiting for emergency and urgent referrals. In order to understand waiting times bench marking had been set across the system, with standard criteria set at 48 hours for an emergency referral, and greater than 7 days for urgent referrals. As there were differences between services work was currently being progressed to refine bench marking for individual services. He said Directorates had been working hard to ensure accurate information, however he recognised there was more work to do in assuring accuracy of information for routine referrals, benchmarked at 28 days. An update report would be provided to the September Board meeting later in the month.  The Director of Strategy and Chief Information Officer said referrals for Neurodevelopment conditions (**NDC**) were high in Buckinghamshire and could be attributed to insufficient commissioning to do the work needed, and a business case was being developed to secure additional funding. He noted the high recording of referrals for the Community Services Directorate but was conscious of the variations between commissioning of services in this arena in being able to reflect the actual reality and baseline benchmark. However, there was good information, and a good position being recorded for Specialised Services.  The Chair thanked the Director of Strategy and Chief Information Officer for the detailed report and suggested a useful development would be for clinician comments to relate the impact on services.  The Executive Managing Director for Mental Health and Learning Disability & Autism Services mentioned CAMHS emergency and urgent referral service was good, and for NDC figures to be recorded separately for Buckinghamshire and Oxfordshire in order to reflect this aspect. She highlighted additional investment received from the Mental Health Investment Services and transformation funding was sufficient resource to clear referral backlogs, however the issue now was a workforce challenge, and work was being undertaken in developing new models of care. A separate issue was a growing waiting list for Improving Access to Psychological Therapies (**IAPT**) services. It had been noted there was a slower patient recovery at the IAPT level 2 service being seen that was being followed up using a QI approach.  The Director of Strategy and Chief Information Officer confirmed for the Chief Executive that he was confident of data quality and accuracy for patients waiting for emergency and urgent referrals. As previously mentioned, work was in progress in ensuring accurate data for routine referrals. It was noted that waiting times were a substantial issue in the Community setting and that the progress in data reporting offered good insight.  **The Committee reviewed and noted the reports at the item.** |  |
| **9.**  a  b  c | **Operational and Strategic Risks: Trust Risk Register and Board Assurance Framework**  The Director of Corporate Affairs and Company Secretary introduced paper QC 38/2021, Operational and Strategic Risks: Trust Risk Register (**TRR**) and Board Assurance Framework (**BAF**) update. She said risk management was continuously being progressed, and for there to be a shift in focus to test and challenge the effectiveness of the control environment for risk. The paper included triangulation of information for credibility and validity of assurances. She asked for the Committee to be alert to the broader risk profile as risk was an area of focus for the CQC .  The Committee reflected on what the target risk rating would be for waiting times and the inevitability of a risk rating remaining indefinitely high. It was noted that scope would be related to capacity and demand and was recognised that turning things around in pressurised services would be a slow process. It was noted that a holistic approach would need to be achieved across those who were attributed risk managers, and for close monitoring to ensure accuracy and relevance of risks.  **The Committee noted the report.**  *Nick Broughton and Katrina Anderson left the meeting.* |  |
| **10.**  a  b | **Clinical Audit**  The Chief Nurse explained paper QC 39/2021 Clinical Audit update had been withdrawn owing to internal pressures and would be presented at the QC in November 2021.  **The Committee noted the update.**  *Sarah Putman joined the meeting.* |  |
| **Quality Improvement** | | |
| **11.**  a  b  c  d | **Quality Objective within the Integrated Performance Report**  The Director of Strategy and Chief Information Officer introduced paper QC 40/2021) stating the paper had previously been reviewed by the Board and an updated version was being prepared for the September 2021 Board meeting later in the month.  The Committee considered the quality objectives and noted that the majority had already been covered in previous agenda items in the meeting or would be covered in later agenda items. The Chief Nurse expressed it was important for the integration of quality indicators as not all objectives may be covered in related papers in a meeting or via the Quality and Safety Dashboard at Item 5.  The Head of Quality Governance updated on the quality objective for staff to be trained in restorative just culture, noting 8 staff had already been trained and a further 17 staff would receive training over the next few months. She mentioned progress was also was being made for the objective in the completion of the Lester Tool for people with enduring Serious Mental Illness (Community), a Tool to assess cardiometabolic health and ensure safe and effective care. A task and finish group were working through actions.  **The Committee noted the verbal updates given.** |  |
| **12.**  a  b  c  d  e  f | **Oxford Healthcare Improvement Centre update (including project update)**  The Head of Quality Improvement presented paper QC 41/2021, Oxford Healthcare Improvement – Quarter 1 2021/22 update report. She accepted the report as read; however, she drew the Committees attention to a new part of the report, the QI Project Spotlight section that focused on the Positive and Safe Programme in reducing restive practice in mental health and learning disability inpatient environments. The project had been established as part of the National Safety Patient Programme that was commissioned by NHSE and Improvement (**NHSE/I**). It had been launched in Q1 across 11 inpatient wards in the Trust and she introduced two colleagues the Interim Ward Manager, Sapphire Ward, and the Staff Nurse, Ruby Ward who would be presenting to the Committee on the progress of the Positive and Safe QI project on Sapphire and Ruby wards.  The Interim Ward Manager commenced by expressing the culture on Sapphire Ward was for a continual reduction in the use of the least restrictive practice. It was priority for patients to feel safe, involved, informed and in control of their care, and to enhance patient experience and satisfaction. It was important for staff to recognise unsettled patient behaviour and to be proactive and to feel confident in applying de-escalation engagement techniques, known as PEACE (Perception clarification, Empathetic Listening, Appreciate Diversity, Collaborative Problem Solving, and Emotional Intelligence). The Ward had PEACE champions and restrictive practice and seclusion was only employed if de-escalation techniques had failed. For all to feel involved easy to follow QI maps and driver diagrams had been generated. Alongside the Positive and Safe Project there was an additional project in increasing activities for engagement during quieter times. She noted there was a downward trend for restrictive practice for the Ward. She said various qualitative data was gathered via feedback from staff and patients, including from IWantGreatCare (**IWGC**) and audited. She added there was a weekly Patient and Liaison (**PALs**) surgery and a regular Carers Forum to provide support and reassurance to patients and families.  The Staff Nurse, Ruby Ward expressed the Positive and Safe Project collaboration for Ruby Ward was similar to that of Sapphire Ward. They too were acting on early warning signs to de-escalate and reduce the occurrence of seclusions and incidents involving violence and aggression. Weekly learning from incidents involving the Ward Team took place to review and inform future practice. A QI message board to continually reinforce the QI project, process and messaging had been placed in a high traffic corridor. She noted there had been few seclusions in the first half of the year, but there had been a slight increase highlighting it was imperative to notice a patients early warning signs in order to de-escalate.  The Chief Nurse reflected on the vision of the project through to delivering it and thanked both for their time, and dedication into ensuring the best possible care was being delivered for patients together with family/carer involvement.    The Chair thanked them both for their time and how valuable it was to receive feedback of the reality of a project  **The Committee noted the Oxford Health Improvement report and Positive and Safe Quality Improvement project presentations.**  *Sarah Putman and Michaela Saunders left the meeting.* |  |
| **Caring and Responsive** | | |
| **13.**  a  b  c | **Learning from Patient Experience update**  The Chief Nurse presented paper QC 42/2021 Experience and Involvement report. She mentioned that feedback via IWGC had dropped throughout the pandemic, but that there had been a significant rise in feedback responses from July 2021 at over 1,000 responses with most being received for services in Oxfordshire Community Services. Alternative ways were being looked at to gain greater feedback for Mental Health Services. The most recent meeting of the newly established trust wide Experience and Involvement Committee had been well attended by services, and service users and carers. The group was leading the refreshing of the Trust’s Experience and Involvement Strategy.  The Head of Quality Governance mentioned the new Carers, Friends and Family Strategy presented at the July 2021 QC had been approved at the 28 July Board 2021. She said the Friend and Family Test question on ‘overall experience’ had achieved a ‘very good’ response rate for Physical Health Services at 84%, and Mental Health Services at 63%, which when compared with national responses was average for both. The results for the 2021 National Community Mental Health patient survey completed in June 2021 would be available and reported on at the November QC. She added the Trust was also participating in a national pilot commissioned by the CQC with 21 other Mental Health NHS Trusts to trial the delivery of the survey via on-line as well as postal. The IWGC contract would be extended for a further 6 months to allow time for fuller consultation with staff and patients prior to considering a tender process.  **The Committee noted the report.** |  |
| **Policies and Governance** | | |
| **14.**  a  b | **Quality Committee Annual Report**  The Chair presented on paper QC 43/2021, Quality Committee Annual Report stating that it was a fair reflection of work that had been undertaken by the Committee over the year. He gave thanks to those in the Corporate Services Team who had been involved in producing the report.  **The Committee noted the report.** |  |
| **15.**  a | **AOB**  The Chair addressed the Committee and said it had been a privilege to be Chair of the Quality Committee during part of his 4-year tenure with the Trust. He recognised the progression that had been made in driving a QI agenda and gave thanks to support from Trust colleagues. |  |
| **16.**  a | **Review of the meeting**  None. |  |
|  | **Meeting closed at** 11:27  **Date of next meeting**  11 November 2021 at 09:00 via Microsoft Teams virtual meeting |  |

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-2)
2. Regular non-member attendees and contributors. [↑](#footnote-ref-3)