Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

Minutes of a Meeting of the AWP NHS Trust Quality & Standards Committee

Held on Tuesday 17th June 2014, 1300-1700

Venue: The Conference Room, Fromeside, Blackberry Hill Hospital.

These Minutes are presented for **Approval**

Members Present

Susan Thompson – Chair & Non-Executive Director
Hayley Richards – Medical Director (in part)
Ruth Brunt – Non-Executive Director
Alan Metherall – Acting Director of Nursing (in part)

Staff In attendance

Alison Devereux-Pearce – Governance Support Officer (minutes)
Sarah Jones – Lead Nurse (in part)
Iain Tulley – Chief Executive (in part)
- Katherine Godfrey – Trust Lead for Occupational Therapies
- Tim Williams – Clinical Director, Specialist Services
- Ann Tweedale - Head of Quality Information & Systems
- John Owen – Clinical Director, South Gloucestershire

Pete Wood – Clinical Director & Consultant Forensic Psychiatrist
Penny Stanbury – Involvement Co-ordinator
Mark Dean – Head of Safeguarding and Named Nurse for Child Protection
Chris Ellis – Consultant Nurse for Intensive Services, Bristol.
Julie Hankin – Clinical Director, Wiltshire
Linda Hutchings - Head of Patient Safety Systems
Eva Dietrich – Clinical Director, North Somerset
Sammad Hashmi – Clinical Director, Swindon
Kristin Dominy – Director of Operations

Part 1 – Business in Public - Specialised Services Presentation

Action

1. Introductions were made and 'A', a Service User of Specialised Services, spoke about her experiences and her recovery journey along with Angie Jakubowska, the Clinical Team Leader for the STEPs Eating Disorder Service, who updated the Committee on commissioned service delivery.

2. 'A' was previously treated by CAMHS in Bristol and then referred later to the Trust by her GP. She was contacted by STEPS for support and was allocated a CPN. Her care was prioritised as she was pregnant at time and had received previous treatment under the Mental Health Act. She received home visits and expressed to the Committee that this was less daunting then when she was receiving treatment through CAMHS as she had been travelling to appointments and sessions.

She added that it was preferable to see someone in her own environment, she felt more respected and that professionals were working with her, giving her help and empowering her to make choices. After the birth of her child she had home visits, saw the Psychiatric Nurse in the Team and received day therapy. She was admitted onto an inpatient ward twice.

3. Angie Jakubowska commented that 'A's family's experience changed when protocols meant that her care was transitioned from CAMHS to Adult Services. As a result of this transition Adult Services were required to obtain her permission for capturing her information and using this in her care, in line with Trust policy for ensuring confidentiality and appropriate use of personal data, but her family and partner were given support by link workers in understanding and respecting this.

4. 'A' reflected that, in hindsight, not all her experiences were positive. Her first admission in hospital for an eating disorder had her experiencing suicidal thoughts with intention, and when she was sectioned she felt that no one cared as she was sent home without feeling ready; she expressed that she didn't feel part of the decision making process, even when speaking up at a ward round she felt that she was not being listened to or negotiated with and that the decision had already been made. This was, she added, the hardest time and she was very bitter.

5. Angie Jakubowska observed that recovery can initially make people feel worse and there is a need to help someone challenge these thoughts. 'A's recovery included a non-negotiable low tolerance for self-harming and an exploration of different ways of dealing with her feelings.

6. The Committee asked 'A' direct questions regarding her experience within the Service:

   6.1 **Were you involved in your care plans?** '*Yes, I received lots of copies; it was my decision and my plan'.*

   6.2 **What one particular thing made a change for you?** *'The ultimatum I was given to not self-harm; it made me think of staying true and if you wanted to get better the staff were amazing but if you don't want that help, no-one can make you want it and I realised it had to come 99% from me. My life was all about the eating disorder; I felt rubbish, so I decided to see how it felt like to change and got stuck in'.*

   6.3 **Can you think of anything that would have improved the experience on your journey or any lessons we can take away for improvements for anyone else?** *'I'm continuing to still see my CPN every two weeks and I'm going to a group at present. I think that the service shouldn't just be focussed on food, self-esteem needs more emphasis. I'm hoping to be discharged in September'.*

6.4 The Chair questioned Angie Jakubowska & Tim Williams about the commissioned Eating Disorder Service as it has a unique boundary focus model, which could be commissioned in other localities..

An acknowledged difficulty is capacity. Since establishment 4 beds has increased to 10 standalone beds with services users waiting to be admitted. This is indicative of the national situation with a trend of greater referrals and a higher intensity of treatment. The service is set up with a variety of interventions, not just admissions. It's also been identified that the commissioning model prevents getting more financial input for the service, but this is a national issue being taken forward at Government level.

6.5 The Clinical Team Leader advised the Committee that the average bed usage has not increased, yet BMI's have decreased with a threshold now of 12. Through liaison with Doctors and the Dietician patients can be directly admitted to a bed and receive very skilled medical stabilisation. This short focus re-stabilising treatment is available but not all CCGs buy into beds for the service.

7. The Committee received a Quality Presentation from Tim Williams, Clinical Director for Specialised Services which was responded to positively. The following items were discussed in addition to slides presented.

- **Compliance Standards** – The figures acknowledge locality stretch targets and lowest standards acceptable. The Team are embedding and making changes which are key to improvements.
- **CQC** – Recommendations have been made over the BAS waiting list but this may indicate confusion by the CQC as BAS and ADHD services are in the same building, but the waiting list is indicative to the ADHD service only.
- **IT Involvement** – There are still no computers etc in clinical spaces in the service building in Bournemouth, but IT are helpful and working to address this. There remains no access for printing prescriptions. This issue was identified only after gaining the service.

8. Penny Stanbury, Specialised Service Involvement Co-ordinator, discussed the upcoming Recovery Festival on 25th July with the Committee and distributed flyers with an invitation for all to attend. The event will be a celebration of people's successes and stories along with other agencies involved in the provision of drug and alcohol services will be involved. It will include Service User and Carer discussions, stalls from Mutual Aid Services, free transport for Service Users and refreshments.

9. The Committee asked Tim Williams direct questions regarding Specialised Services:

   9.1 **Is there opportunity for the comments taken from the Friends and Family survey to make changes?** *The LDU has followed up on valuable comments and has also discussed these in the Performance & Quality meeting with the aim to ''sustain and target' whilst identifying good measures of quality to become standard and embed culturally in the organisation.*

   9.2 **Were these risks known prior to the Bournemouth ADHD Service purchase?** The *issue identified is to deal with the expansion of the business plan within AWP as there's not the capacity to support expansion for the Directorate and preparation for enabling the department is still very slow. It's been identified as a good test case for lessons learnt.*

10. All were thanked for their positive contributions by the Chair.

Part 2 – Business in Private

QS/14/050 - Declaration of Interests

1. In accordance with Trust Standing Orders (s7.1) members present were asked to declare any conflicts of interest with items on the Committee Agenda.

None were declared.

QS/14/051 – Apologies

1. Apologies were received from the following:

Emma Roberts – Director of Corporate Affairs and Company Secretary
Liz Bessant - Interim Deputy Director of Nursing & Head Of Infection, Prevention & Control
Bina Mistry – Chief Pharmacist

QS/14/052 – Minutes/summary from previous meeting on 20.5.2014

1. P3 – *should* read as '*Medical Director'* not 'Managing Director'.
2. With the above amendment, the Committee **resolved** to **APPROVE** the previous minutes.

QS/14/053 – Matters Arising from previous meeting on 20.05.2014

1. **The Committee considered the Matters Arising and resolved to note progress and remove items completed.**

QS/14/054 – Impact Assessments for Cost Improvement Programmes 2014-15

1. The Committee received a report presenting the Trust's Cost Improvement Programme (CIP) Quality Impact Assessment (QIA) position.
2. An outstanding number of QIAs are being sent back for clarification and now include greater detail. The template will be adjusted in regards to clearer risk

scores.

3. The Chair commented that she was unsure in which format the Committee is to receive an update as it needs to understand only in broad terms the challenges to the organisation and receive assurance that the impact on quality of care for Service Users has been assessed.
4. The Acting Director of Nursing commented that the tool used includes alterations to capture policy and service change. He has asked for info from the TDA to ensure that the Trust will continue to have excellent quality processes and will feedback to the Committee accordingly.
5. The Committee **resolved** to **NOTE** the report.

QS/14/0355 – Quality Dashboard Report

1. The Committee received the monthly Quality Dashboard Report from the Director of Operations, setting out performance against the three indicators delegated to the Committee by the Trust Board; Friends & Family, CQC Compliance and Records Management.
2. The following points were discussed further:

   2.1 **Response Rates** – This is new on the report in addition to CQC compliance

   2.2 **Submission rates** – LDU Management is this up taking up with Localities over response levels.

   2.3 **Records management** – The lowest submission rate and rationale was provided by BANES. Teams have asked if including the LIFT Service is appropriate.

   2.4 **Swindon Intensive Team** – Levels reflect the consequence of issues already identified.

   2.5 **IQ Review** - No trend data has been received as yet. The Acting Director of Nursing scheduled this as an agenda item at SMT but was deferred as the meeting discussed the forthcoming CQC inspection at that time.
3. The Committee **resolved** to **NOTE** the report.

QS/14/055.1 – Exception Reports from Localities

1. The Committee received written exception reports from four localities detailing performance exceptions identified and actions to address them.
2. The Committee **resolved** to **NOTE** the reports.

QS/14/0056 – Whittucks Road Action Plan

1. The Committee received action plans and a log of information addressing the outcome of an in-depth investigation report into the culture within the staff group at Whittucks Road**,** a residential rehabilitation and recovery unit. At that stage, the issues related to institutionalised cultural issues impacting upon dignity and respect afforded to Service Users. The Clinical Director for South Gloucestershire advised that the locality may make substantive appointments if

disciplinaries indicate this.

2. The Chair positively commented upon the report and questioned if the Team felt supported as a Locality. The Clinical Director responded that they were but acknowledged that their expectations were perhaps too high for the Academy. He observed that capacity is stretched as there are too few staff available but the plan provided is very good and the locality is working closely with them and staff are looking forward to receiving training in the future.
3. The Clinical Director discussed a meeting with the CEO and Trust Chair addressing actions taken regarding dismissing or reversing decisions made by appeal in which Service User reports of incidents were more readily accepted than staff accounts. This impacted on management feeling undermined in their decision making. The Clinical Director felt the meeting provided a resolution.
4. The Director of Operations gave assurance that there was no question over the judgement of the case, rather the issue was about the appeals process and putting the case together. The Trust had underestimated the difficulties in enabling less experienced colleagues to pull together a position for the disciplinary hearing. This was very unfortunate but she didn't want to detract from how the Team felt.
5. In addition to the locality's dissatisfaction, the '15 Step' Process Report also raised issues which the Clinical Director expressed some concerns regarding the subjectivity of phrases used in the report, particularly as they were made without the context of wider information held in the LDU. The Academy has accepted these concerns and agreed to improve content and processes regarding 15 Step reports in the future.
6. Ruth Brunt questioned if the ambers/reds on the action plan are behind on delivery or uncompleted and if there are risks around delayed progress. The Clinical Director explained that some issues have arisen as a result of awaiting the completion of disciplinaries and these issues will then be addressed. Increasing bed bases depends on meeting with commissioners but items on the action plan are ongoing with the Acting Nursing Director and Medical Director providing assurance until closed down.
7. The Committee **resolved** to **NOTE** the report.

QS/14/057 – Integrated Quality & Safety Plan Q4 Report

1. The Committee received the Quarter Four update of the Trust's Integrated Quality and Safety Improvement Plan (IQSP) which was deferred from the last meeting.
2. 15 actions have been removed as completed and there are two key areas of risk identified: Dual diagnosis training and the Carers pack, which will be monitored by the Executive Team and SMT.
3. The quarterly report in future will be integrated with the Patient Safety Learning Plan and will be scrutinised through CIOG alongside RCAs.
4. The Committee **resolved** to **NOTE** the report.

QS/14/058 – Monthly Incident & Complaints report

1. The Committee received the Monthly Incident & Complaints Report from the Head of Patient Safety Systems which is now reporting quarterly to the Trust Board and monthly through the Quality & Standards Committee.

2. There were 7 externally reportable incidents in May 2014. Each incident is subject to an incident report within 24 hours to identify any immediate actions required, and a Management Report within 72 hours to determine the level of further review at root cause analysis level. There were also 26 formal complaints received in May 2014, all of which are being subjected to an independently led investigation. Prior knowledge of the situation and issues arising mentioned in complaint number 2 was questioned by the Chair who requested that feedback to this is to come back to the Committee as an action.

3. The report contents are also being reported through CIOG, but near miss or incident parameter interpretation is acknowledged to be more difficult to provide. The Head of Patient Safety Systems gave assurance to the Committee that there was nothing to draw to their attention this month.

4. The Committee **resolved** to **NOTE** the report.

QS/14/059 – Quality Governance Assurance Framework Update

1. The Committee received a verbal update from the Medical Director who explained that the Trust need to have an assessed score of 3.5 or less with regards to strategic response and clinical care.

2. A self-evaluation has been performed by the Trust and previously by KPMG. The domain score tested in a Board Seminar is 3 but there have been identified areas of improvement captured within the Quality Impact Assessments.

3. KPMG will now be instructed to provide an additional external evaluation for appropriate score supporting the Trust's Foundation Trust status application with Monitor.

4. The Committee **resolved** to **NOTE** the report.

QS/14/060 – ECT Annual Assurance Report

1. The Committee received the ECT Annual Assurance Report compiled by Jill Emerson, Consultant Old Age Psychiatry and ECT Lead in which it is reported that the Trust's two Clinics have been accredited as 'excellent'.

2. The Chair positively praised the comprehensive report even though the CQC inspection had identified some out of date medicines stored for the service at Callington Road; this has now been addressed and medicines are now appropriately kept.

3. The Committee **resolved** to **NOTE** the report.

QS/14/061 – Crisis Care Concordat

1. The Committee received a report detailing the DoH publication "Mental Health Crisis Care Concordat – Improving outcomes for people experiencing mental health crisis". The Trust is required to work with local partner agencies within each CCG area and produce local declarations and action plans which are subsequently progressed in order to meet the aspirations of the concordat.

2. The Committee discussed place of safety provisions within the localities including the impact of Southmead. An aspirational outcome of the declaration by the government is that it will guarantee parity of esteem with the CCG. It was acknowledged that mental health is more complex but has similar levels of response. The Mental Health Legislation Management Group will be reviewing admissions via 136 suites and how many are already known to service or being admitted via other routes. Any exceptions will be reported into this Committee.

3. One of the featured 12 month priorities is Localities 'buying into' the concordat, but as a result of changes to 136 and challenges related to the use of custody suites, the time to assessment is not within our control for section 12 approved doctors (CCGs) and AMPS. It was evaluated by the Committee as an opportunity to pursue these difficult strategic issues. Ruth Brunt commented that it would be helpful to also see expected outcomes agreed and to what end in the action plan.

4. The Committee **resolved** to **NOTE** the report.

QS/14/062 – Policies

1. Infection Prevention Control and Decontamination Strategy:

1.1 The strategy is supported by the other existing 2 policies presented at the same time that have had minor changes/ been updated to reflect organisation and national reporting and to streamline 19 procedures policies.

1.2 This overarching strategy is part of the vision and aim to support infection control practices across the Trust and the policies that sit underneath this as discussed by the Committee.

1.3 The Committee approved the Strategy.

2. Management of Communicable Diseases Policy: Approved as above.

3. Management of Infection Policy: Approved as above.

4. Mental Capacity Act Policy:

4.1 The MCA policy is intended to support staff in the effective implementation of the MCA and DoLS, to ensure service users' rights are upheld and that staff act in the service user's best interests at all times.

4.2 The policy has been updated to reflect administrative changes due to the reorganization of the structures of the Trust, and the legal changes arising from the amended DoLS application criteria (Supreme Court judgment March 2014) and the change of the supervisory body for DoLS to local authorities to agree return in 1 year or sooner as per the Mental Health Legislation Group.

4.3 The Committee approved the policy with an additional amendment to be made for the 'least restrictive' approach along with an additional instruction reminding people that physical health with incapacitated patients is still within the MHA, which also mentions two alternative regimes.

5. Mental Health Act Policy: Approved as above.

QS/14/063 – Falls Update

1. The Committee **resolved** to **DEFER** the report.

QS/14/064 – CQC Compliance Reports/ Internal Inspection

1. **Callington Road:** The Committee received an update that relates to the previous CQC inspection into AWOL and procedures/ reporting. Hazel Ward is to be rechecked to audit actions and compliance.
2. **CQC Community Review – Action Plan Update:** The Committee was updated by the Director of Operations with assurance that action plans across each Locality are in place to track progress.

   2.1 Wiltshire – Amber/ Red: Teams are now into their new structures, put in place the same day the inspection occurred, so it was agreed that it would be unfair to grade this as complete. The 'red item' will not be completed within June as indicated; assurance was given that this will be scrutinised monthly but will be within place within 6-8 months

   2.2 Bristol is graded as Amber, which KD will take up with the team; Ongoing action is taking place but an updated action plan displaying sufficient improvement needs to be more robust.

   2.3 Previous criticism by the CQC over the Trust not closing compliance reports in a timely fashion was discussed. All actions will be encompassed into a main report in relation to the CQC review.

   2.4 Hazel Ward and Community actions will be reported to the next meeting. The Chief Executive commented that due to the importance of the actions it wouldn't be prudent to wait for next meeting of the Committee and that immediate actions taken can be reported back to the Committee.

   2.5 Wiltshire's teams have changed into 4 CMHTs functioning within models with supervision. The Medical element is almost concluded with Therapies moving in August which means the LDU will have 4 fully functioning teams, but it was acknowledged that this won't show progress initially.

   2.4 RiO changes made to data collection are in place but the Committee won't see changes until September onwards.
3. The Committee **resolved** to **NOTE** the reports.

QS/14/065 – Committee Terms of Reference

1. The Committee received and reviewed the Committee's Terms of Reference.
2. Membership and quoracy were discussed and the inclusion of the Director of Operations as a member was debated, but the Committee were unsure if Clinical Directors were to be included in attendance.
3. Comments were sent by the Chair to the Corporate Governance, Risk and Legal Manager regarding membership and 'releasing ' Clinical Directors from attending but not all could be incorporated. The issue regarding accounts given at the meeting by CDs has been taken as assurance and felt to be useful by the Chair but in the future a written report is required to track progress and accountability.
4. The CEO commented that there is no criticism over what the Committee has done, rather it requires discipline around the agenda and who will be expected to attend to provide assurance. He suggested that actions arising from the Quality Huddle would identify CD's to attend on any particular month when the need arises to give assurance.
5. The Committee discussed 'calling to account' by the Clinical Directors and the CEO observed that this assurance needs to be defined and the way in which the agenda is set needs to allow assurance and appropriate scrutiny.
6. The Chair summarised the discussion outcome as follows:
   - 6.1 CDs are invited to still attend (or delegate) and are expected to provide a written exception report. If no exceptions then need to declare none.
   - 6.2 The Committee requested that the Director of Operations become a member of the Committee, and for this to be reviewed in one year's time.
   - 6.3 Quoracy was discussed and was recommended to be 1 NED & 1 Executive member (either the Medical or Nursing Director)
7. The Committee **resolved** to **NOTE** the ToR comments/ recommendations & the Chair to take up with the Chair of the Trust.

QS/14/066 – Any Other Business

1. None was identified

QS/13/067 – Agree any items to escalate to Board or horizontal reporting to other Committees

1. Board Appeal Training to be discussed at ESEC by the Chair, Ruth Brunt.

Next Meeting:

1300-1600 15th June 2014, Maple Room, Jenner House