Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

Minutes of the AWP NHS Quality and Standards Committee Meeting

Friday 19th August 2014, 1300-1600

Conference Room, Callington Road, Bristol

These Minutes are presented for **Approval**

Members Present

Ruth Brunt – Chair & Non-Executive Director

Hayley Richards – Medical Director

Staff In attendance

Alexander Lauder-Bliss – Governance Support Officer (minutes)

Ann Tweedale - Head of Quality Information Systems

Tony Gallagher – Chair of the Trust

Newlands Anning – Head of Profession and Practice, Swindon

Sarah Harding – Practice Development Nurse

Liz Bessant – Head of Nursing

Eva Dietrich – Clinical Director, North Somerset

Peaches Golding – Non-Executive Director

James Eldred – Clinical Director, Bristol

Tracy Clack – Service User Director

Pete Wood – Clinical Director, Secure Services

Public In attendance

None

Action

Part 1 – Business in Public

QS/14/085 – Bristol Locality Presentation

1. Introductions were made and the Chair welcomed the Bristol Team. The Committee positively received the Quality Presentation from James Eldred, Clinical Director for the Bristol Local Delivery Unit. The following items were discussed in addition to the slides presented:

1.1. Service User Director Role/Service User And Carer Board – To ensure that Service User experience is central to the new Bristol model, a Service User Director Role has been set up for each Lot alongside a Board consisting of Service Users and Carers.

1.2. Building Up the Service User Base – To ensure fair play and positive outcomes for Service Users.

1.3. Quality Monitoring – Quality Meetings are held monthly for the Locality and for the Acute, Recovery and Later Life Pathways. Issues are escalated to the

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Trust Critical Incident Overview Group (CIOG)/Senior Management Team (SMT) and fed back down through the pathways/Team Meetings. Regular Standing Agenda Items at Locality and Pathway Meetings Include: Friends and Family test, CQC, IQ data, CQUINS, incident reporting, medicines management, Patient Safety Development Plan, audits, safeguarding and complaints. Bristol CIOG meetings are held monthly and look at trends, themes and issues related to SUI's and complaints. All of the Bristol SMT attends.

1.4. Discussion was had regarding staff morale with many feeling uneasy as a result of past experiences of large scale change, resulting in a need for the Trust to demonstrate faith in the leadership teams.

1.5. The System Leadership Team has been set up, consisting of the System Leader, Leadership Clinical Lead, Service User Director, and Partnership Director.

1.6. A system has been introduced so Service Users can record their day to day experiences helping with measurement of the minute details and bring the scoring to the front line.

1.7. Implementation of change will be phased, by introducing the new model into small clusters of GPs in different areas to help with learning for implementation.

2. JE gave a summary of performance with details on CQC compliance and Records Management, outlining actions being taken to resolve any issues flagged as amber.
3. Safety and Suitability of Equipment was amber due to a small number of staff not having undertaken updated fire training.
4. JE stated that they have looked at 7 day follow up as the figures were unusual. Previously, scores have been green, with a particular issue with one ward which has been addressed, highlighted as recording issues.

QS/14/086 – Questions from the public and attendees

1. HR asked JE how the locality CIOG and locality quality meetings report to the Trust-wide CIOG and other meetings. JE raised that there will be some duplication to begin with but Bristol looks at all incidents in the locality rather than the Trust-wide CIOG which only looks at high risk incidents. ED reflected that a similar approach has been taken in BANES so management can focus in on improving quality.
2. TG commented on the Commissioners initial 3-6 month implementation time was unrealistic, emphasising a need to engage with Commissioners in a constructive way. JE highlighted that, as System Leader, he has a key role in co-ordinating this. TG supports rolling out a system leader structure Trust-wide in line with learning from the Bristol tender. TG also raised that discussion at the Trust-Wide Involvement Group highlighted the issue of paying carers and service users for their time. This has identified a need for a consistent approach to gratuities where it

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is identified what type of work will be paid.

3. RB asked for additional assurance on controlling the impact of change for staff, the effect on the quality of service provided and the overall service user experience. JE stated that there is challenge around reporting this but after the results of the last Friends and Family Test, the leadership team has pushed for identified champions to cascade information down to the front-line. JE expressed confidence that there has been no impact and that it shows how important a phased implementation is.
4. PG asked if any conversation had taken place with GPs. TC stated that Will Hall has had direct conversations with GPs and in June/July there had been a GP event with over 80 GPs in attendance. The event discussed the new model with 'short and sharp' messaging. It was discussed that GPs all have a variety of requirements and expectations, with value placed on clinical leadership in the city. JE stated that the locality had piloted a primary care/psychotherapy consultation process which had previously only been done in East London. After a three month review, the system was presented to the Commissioner to help with continuing to provide this service. This was noted as a learning point for other localities to gather evidence then have conversations with Commissioners to formalise.

QS/14/087 – Close of Public Session

1. All were thanked for their positive contributions by the Chair who reflected upon the large amount of work been done in Bristol with increasing pressures due to the successful bids.

Part 2 – Business In Private

QS/14/088 – Declaration of Interest

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.
2. None were declared.

QS/14/089 - Follow up discussion & questions – Bristol Locality Presentation

1. The Committee followed on from the Bristol Locality presentation with a deep dive into locality quality issues including;
   1.1. Contract and Monitor Quality Indicators
   1.2. CQC Compliance
   1.3. Records Management
2. CQC Compliance was reported as 91.2% which is 1.6% below Trust-level. JE raised that there was great variance between teams but the score was due to some staff not completing their training. HR highlighted that the uptake of stat/man training is a priority for the Trust currently as this is a Trust-wide issue. ED stated that the email reminders were very helpful for clinical staff. HR raised that there were challenges within non-clinical staff groups with a sense of lack of ownership

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and understanding of who holds managers to account. The Committee was satisfied that actions are in place to resolve this.

3. Records Management has an overall score in Bristol of 87.2% which is above the Trust score of 86.9%. The Formulation summary recorded was identified as an outlier at 74.4% against 77.9% Trust-wide. The Committee raised this as a concern. ED raised that additional training is taking place in BANES to resolve this issue. NA expressed that there is a lack of understanding on this but training is being tailored for each team's requirements. The Committee recognised that training that has been implemented recently will have a lag factor in the reporting. This remains a key priority for the Trust.
4. Contract and Monitor Quality Indicators were showing amber on 7 day follow up and service users with an annual review. The Committee requested that actions being taken by Bristol for the slippage on 7 days follow up to be included in the next exception report. – **ACTION: JE** **JE**
5. ED raised queries around the Governance of the new Bristol model in light of the different service providers. JE stated that there is a service delivery body with the system leader above and the providers will be working to the Trust's policies and procedures.

QS/14/090 - Apologies

1. The Chair gave a reminder to the LDU leads that in the effort to expose actions taking place to improve quality, extra effort needs to be placed on getting public representation to the Committee.
2. Apologies were received and noted from the following:

Susan Thompson
Alan Metherall
Emma Roberts
Bina Mistry
Katherine Godfrey
Linda Hutchings
Emma Adams
John Owen
Kris Dominy

QS/14/091 – Minutes/Summary of the meeting held on 15th July 2014

1. The minutes of the previous meeting were approved as accurate and correct.

QS/14/092 – Matters Arising

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

QS/14/093 – Quality Dashboard Report

1. The Committee received the monthly Quality Dashboard Report setting out

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performance against the three indicators delegated to the Committee by the Trust Board; the Friends & Family test, CQC Compliance and Records Management.

2. The Committee noted the steady improvement with the Friends and Family test but expressed concern with the 'flat line' on some CQC Compliance areas.
3. The Committee acknowledged significant variance across the Trust for the Friends and Family test highlighting a need to get more accurate data at team level.

QS/14/093.1 – Exception Reports from Localities

1. The Committee received written exception reports from the Trust's localities detailing performance exceptions identified and actions to address them.
2. Points to note included:

2.1. BaNES: A service user suspected of homicide whilst in inpatient PICU has raised concerns for the Trust about assurances regarding the quality of private providers. This quality assurance is under consideration by Alan Metherall. PG raised a question regarding tracking AWOL patients out of area (OOA) with HR stating that they are treated as Serious Untoward Incidents but the responsibility lies with the provider.

2.2. Swindon: Sammad Hashmi stepped down as CD with Simon Manchip taking up the post temporarily. NA raised that the Intensive Team remains a particular hot-spot but caseloads have been reduced to a manageable size of 29, cultural review completed, and the HoPP continues to conduct independent CQC self-assessment and Records Management audits, as assurance over improvement. Assurance was provided that robust action plans were in place. NA raised that there is a constant pressure on bed management and OOA placements. HR discussed the current process in place and challenges in the system skipping other NHS providers for OOA care. The Committee raised that conversations had been had with neighbouring localities about their capacity as part of an escalation process. TG stressed the need for a solution in this area as it has become a real concern for the Trust, with greater visibility at Board. The Committee resolved to bring this back for the next meeting. The Committee asked HR to give consideration to what is reported and how often to report on the quality of patient experience for OOA to demonstrate and evidence what is being done. – **ACTION: HR** **HR**

2.3. South Gloucestershire: No issues raised; the locality is scoring consistently high in all areas. The Committees attention was drawn to the 15 step review to be undertaken at Whittucks Road to ensure that the actions implemented there have been successful in addressing previously reported concerns.

2.4. Specialised Services; No areas of concern were raised.

2.5. Secure Services; PW drew the Committees attention to the 60% response rate as incorrect with the correct figures being 20.4%. This was due to service users becoming unresponsive due to the repetitiveness of the questionnaire over time. A safeguarding lead has been put in place at

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Fromeside. The records management low score is being remedied by having service users involved with risk assessment with improvements being shown next month.

2.6. North Somerset; ED updated the Committee on the exception report. Attention was drawn to the 4 suicides in the locality. This has put pressure on anti-ligature work, particularly in Juniper Ward. Anti-ligature assessments had already taken place but a service user hung themselves in Juniper Ward was not in a previously identified ligature point and advice is needed. There is a downward trend with supervision but this is being address at local quality meetings. There is on-going pressure on acute with 27 people in 20 beds. ED gave praise for the collaborative work being done across teams.

3. The Committee noted that Wiltshire had no exception report this month as Audit and Risk Committee had reviewed the risk register. It was raised that an exception report from Wilts is presented next time.
4. The Committee resolved to **NOTE** the reports.

QS/14/094 – CQC Compliance Reports/Internal Inspection

1. The Committee received reports from Liz Bessant, Lead Nurse, confirming that actions are in place as per recommendations.
2. LB gave background information on what has been done to date, including an Ourspace page, locality action plans following verbal feedback from CQC, a Sycamore specific action plan, and ligature work at Fromeside. However, there has been no formal written feedback from the CQC.
3. LB stated that weekly CQC meetings are held to go through the action plans in detail, and updates on progress are recorded weekly.
4. It was raised that there are regular visits to each locality to check CQC compliance and the quality summit with the CQC will take place on 10 September.
5. LB reported no high risks across South Gloucestershire, North Somerset, BaNES, and Swindon.
6. The Chair asked for feedback from locality leads in which NA and ED both were content with what was being presented.
7. LB discussed issues arising at Bristol, Secure, and Wiltshire; Particular emphasis was placed on the S136 place of safety at Green Lane Hospital in regards to dignity and respect and the environment. Since the inspection, furniture was ordered and is due w/c 18 August. However, no curtains have been ordered which has led to further concerns regarding dignity and respect issues. The actions/recommendations underway are to be discussed at the weekly CQC meeting.
8. JE expressed confidence in using the Manchester Tool to measure risk. It was discussed that risk assessments were being measured as poor reports so it has been actioned to give staff additional training. HR stated that it has been challenging to mitigate due to staff declaring self-confidence but then being

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assessed as poor. HR raised that this should be brought back through supervision and appraisal as required.

9. LB raised that Pharmacy have been having issues going through the Medicines Management action plans and require further clarification on actions taken, but no major risks have been flagged.
10. LB stated that previously there was a concern that the corporate actions were not being addressed but this has been resolved with no major risks flagged.
11. It was discussed that additional external assurance was provided from the Trust's Internal Auditors, Baker Tilly, and has been reported to the Audit and Risk Committee.
12. LB stated that the Bed Management action plan had been author reviewed and has since been sent to Kristin Dominy and Kevin Connor.
13. LB discussed the Sycamore Ward transformation, stating that she was very impressed. Staff who had not been to Sycamore Ward previously were sent to there to review. However, the decoration still needed to be completed. The Managing Director has initiated the recommendations to install a curved mirror for visibility.
14. There was detailed discussion on Fromeside, including removing the doors from the en-suite bathrooms to allow better observation of high-risk service users, however, this causes a privacy and dignity issue but an anti-ligature solution is needed. It was further raised that the curtains in the rehabilitation ward are not consistent but this is currently being addressed with contractors.
15. PW raised that there are cost issues with replacing the windows to the anti-ligature standards which has raised costs considerably above the costs originally discussed to address those issues that the CQC inspection raised. The works are progressing and will be complete by the end of December 2014. HR raised that Sue Hall is meeting with the CQC to discuss the cost implications. TG raised a question regarding external works with LB stating that work done has been internal. ED raised that the Commissioner should be informed that additional costs may be raised by any changes flagged from the CQC inspection.
16. The Committee was content with the report and thanked LB and the localities for the work done.
17. The Committee **NOTED** the report.

QS/14/095 – Learning from Experience Report

1. PG left the meeting at this point.
2. The Committee was presented with a report on the learning of the Trust during quarter one of 2014/15.
3. The report gave an overarching record of the Trust's organisational memory in respect of learning during quarter one. No significant issues were raised but it gave a flavour of the different learning opportunities and responses. The introduction of

Action

the Patient Safety Development Plan was reported as being instrumental in strengthening the Trust's processes with regards to learning. Medicines issues feature prominently. In response to this, medicines was included in as a focus in the Integrated Quality Action Plan.

4. The locality leads stated that they found the report very helpful.
5. Attention was drawn to page 8, on the themed findings being placed against the CQC domains.
6. NA raised that the CCG expectations may be too high with HR raising that conversations are taking place with the CCG to explain the Trust's position. The Trust is working with NHS England for SUIs and templates that have been escalated. Hayley stated that she has ownership of this and will chase this issue.
7. RB asked what learning was being evidenced for disciplinary and appeals etc. It was raised that there is no way for managers to report this and the Committee resolved to explore this. – **ACTION RB/KD.** **RB/KD**
8. The Committee resolved to **NOTE** the report.

QS/14/096 Annual Clinical Audit Report & Work Plan

1. The Committee received a report that outlined findings from the Clinical Audit work plan and actions arising from this.
2. The report gave a summary of key achievements throughout the year and the current position of the Trust.
3. Key highlights from 2013-14 included:
   - 3.1. Delivery of a comprehensive programme of clinical audit encompassing Trust wide, and local priorities with participation in national audit programmes.
   - 3.2. The audit plan was streamlined working with colleagues to review the need for some routine trust wide audits and develop alternatives to meet more current priorities.
   - 3.3. Development of audit team skills to register and support other quality improvement projects.
   - 3.4. Closer working with the Deaneries to streamline approval of smaller audits, to support doctors' revalidations.
   - 3.5. Certificates of achievement are issued to support appraisal and revalidation.
   - 3.6. Development of a training programme for Post Graduate Education Meetings, the addition of eLearning and a series of workshops.
   - 3.7. Overhaul of the Clinical Audit information pages on Ourspace.
   - 3.8. Completed a project to confirm completed actions from previous audits.
   - 3.9. Completed a project to review NICE Implementation.

Action

3.10. Reviewed and updated the Clinical Audit and Strategy.

3.11. The audit department is now part of the Quality Academy

4. The priorities for 14/15 were outlined as such;

4.1. Continue to focus on delivery and continued development of the annual plan as set out in Appendix 1 of the report.

4.2. Work toward ensuring all SDUs are participating in clinical audit and providing specialist support for the local completion of the audit cycle.

4.3. Identify best practice, measure against criteria, take action to improve care, and monitor to sustain improvement.

5. Assurance was provided that the Trust is in a better place at this time when compared to last year.
6. AT outlined that a mid-year report will be made to keep the Committee sighted.
7. Currently, a system is being implemented for risk assessing every completed audit based on the same framework for risks. This is will form a basis on how things would be escalated.
8. The Chair expressed that it is key to align a top down Trust strategy with the bottom up approach being taken here.
9. TG emphasised that the data reported should be going to the Audit and Risk Committee with any clinical issues coming to this committee.
10. The Committee was content with an interim report coming back to Quality and Standards later this year.
11. The Committee discussed the level of reporting, settling with Quality and Standards making a recommendation to go to the Audit and Risk Committee to ensure that this Committee is sighted on any quality issues with Audit and Risk Committee assigned to resolve.
12. The Committee **NOTED** the report.

QS/14/097 – Annual Incidents Report

1. The Committee received the annual report on Incidents across the Trust.
2. The report highlighted a number of very positive findings about the performance of the Trust in terms of incident reporting. It also identified a number of actions that need to be taken by Delivery Units and the Trust to improve the Trust's ability to learn from the incidents that happen. Primarily, these related to improving the incident reporting culture in some areas; improving the quality of the information collected and ensuring that incidents are reviewed promptly at a local level.
3. As of March 2013, a new electronic system was implemented that demonstrated a 20% increase in reporting and, in particular, there was an 80% increase in reporting with medicines incidents.
4. It was discussed that the Trust relies heavily on timely closure and managing of

Action

actions by team managers. In July, the Trust reported 466 incidents waiting to be addressed.

5. It was raised that trips and falls are to be included into the reporting in the near future.
6. The Chair raised that Board requested self-harm to be reported separately by the Patient Incident Team. There has been an increase in ligature incidents and, nationally, there are efforts to benchmark. Hanging is particularly on the rise.
7. The recommended actions included asking delivery units to explore the variability in each area and to provide a timely review by the team leaders.
8. TG asked the Committee to note that time lag has gone from 57 to 15 days which is a marked improvement.
9. The Committee also noted that for the comparative reporting rate, as reported on page 5 of the report, there was a marked difference between the top performing Trust and the bottom with the Committee recommending benchmarking of the top scoring Trust.
10. The Committee commended the work done by the Patient Safety Team and the work done for reporting near misses.
11. The Committee resolved to **NOTE** the report.

QS/14/098 – Critical Incident Overview Group (CIOG) Annual Report

1. The Committee received the CIOG report for information.
2. It described the work done in the past year by the Group and outlined interactions with Commissioners.
3. It was discussed that the Trust will continue to strive to do work that meets the requirements of patient safety, and to move forward innovatively.
4. The Committee resolved to **NOTE** the report.

QS/14/099 – Safeguarding Annual Report & Report from Safeguarding Group

1. MD presented the annual report on Safeguarding.
2. The revised report and the attached appendix A covered the period 2013/2014 and 2014/2015 to August) and detailed key issues, risks and actions for 2013/2014. The report covered a range of different safeguarding and public protection work streams, namely:
   - 2.1. Safeguarding children
   - 2.2. Safeguarding adults at risk
   - 2.3. Domestic abuse
   - 2.4. MAPPA
   - 2.5. Prevent

Action

2.6. Historical abuse

3. It also outlined that there have been considerable changes to national and local policy, standards, activity levels and performance frameworks during the period covered by the report.
4. The report noted the information on current compliance with required standards, and the areas and planning to ensure continued compliance in areas where standards have, or will be amended.
5. The Quality and Standards Committee was asked to approve the report and its conclusions, and the work plan.
6. MD raised that modern-day slavery will be a pressure in the near future.
7. TG raised that the report needed to look at how safeguarding will be impacted by the Trust's future plans around expansion and increase of services. TG recommended that a report be provided to the Trust Board. – **ACTION: MD**.
8. The Committee resolved to **NOTE** the report and approve the work plan. **MD**

QS/14/100 – Quality Account – Progress with Improvement Priorities

1. The Committee was provided with a report on the Quality Account for the first quarter.
2. The report showed work is on track for all domains showing a moderately positive projection of improvement.
3. HR asked localities to feed back to the Committee in the next meeting on the approach they have taken to embed physical healthcare monitoring and intervention into routine care for all inpatients, on all inpatient units, as per the parameters of the CQUIN. – **ACTION: All CDs.** **All CDs**
4. The Committee resolved to **NOTE** the report.

QS/14/101 – Integrated Quality & Safety Plan – Quarterly Report

1. The Committee received the Integrated Quality & Safety Plan (IQSP). It outlined the Trust's position for Q1.
2. The Committee was informed that they had been sighted on this at a previous meeting. It was raised that the report was a new iteration as discussed with Commissioners.
3. The plan set out the Trust's quality improvement priorities and other key areas of Trust-wide quality improvement activity into one overarching summary document.
4. The Quality and Standards Committee was recommended to note the progress with the attached IQSP and the revised format for the Trust's consolidated quality and safety improvement plan for 2014/15.
5. Eleven key objectives and/or quality improvement areas were included from the following sources:

Action

5.1. Quality Account quality improvement priorities for 2014/15

5.2. Operating Plan Quality Ambitions and CQUINs.

5.3. Key actions in response to serious incidents, complaints, external reviews and quality improvement visits.

5.4. CQC compliance improvements.

5.5. The Trusts Medicines Optimisation Strategy.

5.6. The key issues or areas of risk there Committee were asked to noted were:

5.7. Low uptake of the NPSA suicide prevention toolkit as part of the unexpected death review process. This will be considered by the Critical Incident Overview Group to agree remedial action.

6. The Committee were content with the report with HR emphasising the need for HoPPs to lead on patient safety.
7. The Committee resolved to **NOTE** the report.

QS/14/102 – Quality Governance Assurance Framework Update

1. A verbal update was provided to the Committee from HR highlighting that the Trust is required to have a complete quality governance assurance framework (QGAF).
2. It was discussed that the evidence is in the process of being collated on the last assessment in readiness for KPMG to perform a review.
3. The outcome of the review will be coming to this Committee in the future.
4. The Committee resolved to **NOTE** the report.

QS/14/103 – Physical Health Checks Policy

1. The Committee reviewed the Physical Health Checks Policy.
2. It was highlighted that the policy had been completely re-written with more focus on better direction for clinicians on what should be assessed. The policy has been brought in-line with the EPR project, and aligned with other physical health care policies/guidance via hype linking.
3. The Committee resolved to **APPROVE** the policy.

QS/14/104 – Resuscitation Policy

Action

1. The Committee reviewed the resuscitation policy.
2. It was highlighted that changes have been made to separate the policy and procedures as required.
3. It was discussed that more guidelines in regards to Mental Health were released in May 2014, highlighting a need to come back February 2015 with more changes.
4. The Committee resolved to **APPROVE** the policy.

QS/14/105 – Safeguarding Children Policy

1. The Committee reviewed the Safeguarding Children Policy.
2. The policy now incorporated process and practice changes agreed by Trust Safeguarding Management Group. This ensures better quality in reporting. Other changes included new administration arrangements and safeguarding in respect of conferences.
3. The Committee resolve to **APPROVE** the policy.

QS/14/106 – Safeguarding Adults at Risk Policy

1. The Committee reviewed the Safeguarding Adults at Risk Policy.
2. The changes on the policy reflected AXA and CQC and pulled in information from the personalisation agenda.
3. It was further discussed that the policy covered risk issues for supervision and covered issues around respect with deceased service users, in-line with Department of Health recommendations.
4. The Committee resolved to **APPROVE** the policy.

QS/14/107 – Any Other Business

1. PW raised an issue around staffing levels in Secure Services. It was raised that a Whistleblowing issue occurred regarding nursing staff in Fromeside. Iain Tulley visited Fromeside and confirmed the issue which had been included on the risk register for a period of time. PW further raised that an action plan created by LB has gone to the CQC. PW and LB provided assurance that measures were now in place to negate the issue.
2. It was then discussed that this may not be viable for the long-term. It was raised that the Employee Strategy and Engagement Committee will be looking at recruitment and retention issues.
3. TG highlighted that Emma Roberts is exploring/revising the process and procedures as another locality is having a similar problem. TB also raised that there is on-going national debate on how to handle whistleblowing.
4. TG also emphasised the need to review risk registers in detail to prevent this happening again.

Action

5. HR raised that the Executive Team and Audit and Risk Committee have added recruitment to the Risk Register on a locality by locality basis.

QS/14/108 – Agree any items to escalate to Board or horizontal reporting to other Committees

1. The Chair agreed that the following issues will be escalated and reported as required:
   1.1. Safeguarding in regards to Trust strategies
   1.2. Report on Wiltshire
   1.3. Provide information on DTOC and Bed Management Issue.

Next Meeting: 1300-1600 16th September 2014,The Beech Room, Sandalwood Court. Locality Presentation – Swindon.