Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

Minutes of a Meeting of the AWP NHS Quality and Standards Committee

Held on 15 December 2014 at 1.30pm in Seminar Room 4, Jenner House, Wiltshire

These Minutes are presented for **Approval**

Members Present

Susan Thompson (Chair) – Non-Executive Director	Kristin Dominy – Executive Director of Operations
Barry Dennington – Non-Executive Director	Alan Metherall – Acting Executive Director of Nursing
Ruth Brunt – Non-Executive Director	

Staff In attendance

Alexander Lauder-Bliss – Governance Support Officer	Ann Tweedale – Head of Quality Information and System
Denise Claydon – Managing Director of Wiltshire	Linda Hutchings – Head of Patient Safety Systems

QS/14/167 – Apologies

1. Apologies were received from Emma Roberts, James Eldridge, and Hayley Richards.

QS/14/168 – Declaration of Members' Interests

1. No interests were declare.

QS/14/169 – Minutes of the Meeting of 18 November 2014

1. The Committee requested that the recording of the meeting be kept for three months to ensure that any queries relating to the minutes could be resolved.
2. ST had sent corrections to ALB prior to the current meeting. ST suggested that the discussion around pharmacy and medicines management in light of CQC concerns and the difficulties concerning equipment and pharmacy within the current model could be reflected in the minutes.
3. ST suggested alternative wording on the subject of zero hours contracts and the relating negative publicity, which she had sent to ALB prior to the current meeting.
4. ST turned to item 5 of page 2: the use of technology and mobile working. ST suggested that the Committee could ask the Finance and Planning Committee (F&P) to reconsider the gains from the mobile technology, in order to recognise the benefit and to evaluate whether the scheme achieved its objective. ST outlined that it was likely the quality benefits that were anticipated from the scheme had not been realised in full and that it would be good to flag it up to F&P. **– ACTION KD**
5. ST highlighted item 4 of page 5, which pertained to the Learning and Experience Report. There was prompt feedback from the risk team about lessons learned at both team and locality level, which ST felt gave positive assurance to the

Committee, but had not been included.

6. The minutes were approved as an accurate record with further minor grammar and spelling corrections.

QS/14/170 – Matters Arising From the Previous Meeting

1. ST turned to the subject of the Quality Impact Assessment Bristol (QIA), completion of which was outstanding for the year. There was a QIA on Bristol to update on progress for new services and tendering exercises. KD confirmed that the action remained outstanding; she would pursue this as James Eldridge was currently absent on sick leave.
2. KD foresaw that a definite shift in caseloads would occur, alongside the capacity within the secondary mental health side of the service with the support of the recovery navigators. There had been inconsistent improvement around CPA for service users, with 122 service users on CPA that had not had a review in the last 12 months. KD summarised that the QIA of the new model was largely positive, and that the bringing together of older adult and adult services in the three areas across Bristol was largely positive. There was a lag in the implementation around the recovery navigators, which would have a positive impact when it came through.
3. RB asked if there were indicators which the Committee needed to be sighted on for Bristol specifically, until the situation had been resolved. KD confirmed that she had asked for a mapping exercise to be undertaken, whereby the new model was overlaid on the old model to give a clear picture of where the staffing was.
4. RB emphasised the importance of understanding the impact on patient experience. She proposed that James Eldridge could be given greater discretion on the research being undertaken in Bristol. ST had looked at the mental health dashboard, which gave a good indication as to quality. ST asked that James attend the next Committee, to set out the impact on quality of the transition, with reference to contract quality indicators and any other indicators the executives deemed to be important. An early report relating to access to intensive services indicated a dramatic impact on the service user experience, but they did not know whether that improvement had been maintained. ST did not think the Board was well-sighted on the issue of the transition in Bristol.
5. KD noted that a fortnightly Bristol call was in place where similar issues were addressed, such as system leadership update, transition issues, and what was not going well. The estates issue, medical issues and governance were the main focus. RB asked why the Board was not sighted on the key issues identified during that call. Lee O'Bryan (LOB) chaired the call, and had invited Board members to attend. RB requested a process whereby it was escalated to the Board or for LOB to be responsible for reporting back key issues to ensure they were sighted.
6. Establishment of the Patient Safety Team: LH updated that she is taking a paper to CIOG in February 2015. A paper will then be prepared for F&P for March.

QS/14/171 – Quality and Performance Report and Exception Reports from Localities

1. KD presented the Quality & Performance Report with an overview of the three quality indicators that had been designated to the Committee. There were no exceptions to report on Friends and Family, CQC, and Records Management. The report made a note that Friends and Family will be mandated for mental health trusts in January 2015, with the first data collection period in January to be reported in February. It came with an amended scoring approach that will provide the % of those that would recommend and the % that would not recommend.
2. In terms of record management submission, two teams did not submit for the last month. This was in line with reporting under-performance in Bristol and Swindon.
3. In relation to the CQC Compliance, the Committee was aware that they were not reporting against the new standards for the five domains and that the discussion at the executive team was to suspend the current CQC self-assessment. The team was working through all other associated processes using the five domains. Ongoing actions which had been taken in respect of CQC included the Check and Challenge Process.
4. The Improvement Team was being led by Rebecca Eastley. A number of different work streams had been picked up along the way, including ligatures, a trust-wide garden audit, and picking up issues in relation to pharmacy, which were defined as medicines management and pharmacy issues in themselves.
5. Work was on-going to develop the week in focus, and LH and KD were working to undertake the first assessment in the first week of February. The team were looking to provide a shadow rating, with a clear justification to the locality. As momentum and competence increased the pool of those looking at other services would be increased, so peer-to-peer review as opposed to a Trust central team. KD hoped that expertise and knowledge would be developed in relation to assessing themselves against neighbouring localities.
6. KD updated that she had growing confidence in the localities having robust systems for ensuring the outcomes of actions they were taking. While the process was challenging, localities had taken a firm grip on the CQC actions.
7. In relation to bed pressures, tables were identified from page 4 of the report onwards. KD highlighted that the initiative to admit to a home locality was largely positive; fewer and fewer people were admitted out of home locality, which had a very positive impact on the acute care pathway, both from an intensive team perspective and a ward perspective. KD added that there were still pressures in relation to the need for out-of-area placements. As of the previous Friday there were 24 patients out-of-area, which constituted a significant reduction from two months previously. Further, there was a reduction in occupancy in older adult wards and in intensive care areas, despite the fact that three beds had been lost in Ashdown.
8. KD turned to the ongoing issue of up to 45 patients out of AWP CCG area, but within AWP services, and while that was unexpected in some parts, it was something they had to 'live with' as some patients would be from out-of-area. A discussion had been held with commissioners in the previous week, who had admitted that their own processes need to be more robust and that it was necessary to be more aware of patients' whereabouts to ensure they were

returned to their home area.

9. The Chair asked if there were issues around returning the out-of-area patients to their own homes. KD replied that when spot purchasing beds in Devon there was a significant challenge getting those patients back to UCH when their health deteriorated. KD added that this information was being recorded to ensure greater visibility for the Trust and the commissioners. ST understood that there was a suggestion that out-of-area patients were likely to have longer stays, because they were not integrating with local teams and families to step down out of hospital. Therefore there was a direct impact on the service user in terms of their experience being cared for out of their area.

10. BD asked if out-of-area patients usually returned to a Trust location. KD confirmed that was the case. He asked what the process was for understanding the severity of their out-of-area access, and how you prioritised patients who were coming back soonest. KD replied that the issue was clinical. DC added that depending on the clinical presentation you tried to be as practical as you could be to prioritise the return of people in harder to reach areas. BD asked how often patients were reviewed to determine whether they could return home. DC explained that reviews were on-going, because they were so aware of a bed becoming available and needing to prioritise who would be returned.

11. KD noted that the Finance and Planning Committee had asked for the early observations report on the acute care pathway review to be presented to the Committee. She suggested that the issue was equally relevant to the Q&SC, and that it was possible to share the relevant paper. RB asked what the financial planning slant had been. KD clarified that the focus had been on the cost of out-of-area to the health economy, and also in terms of business planning and where they should be thinking about looking at development opportunities. They were considering development opportunities around the PD pathway, acute step downs, enhanced care and the possibility of intensive day care services. **– ACTION KD**

12. KD suggested that it would be beneficial for the Committee to review the paper and information in question; the Chair agreed. RB suggested that it would be beneficial for the clinical executives to add their perspective on the paper, to present to the Committee. The evidence would be analysed and the assumptions brought together during January. This could be put into a paper identifying the options and recommendations in respect of the quality side of the proposal; they would also do something similar for Finance & Planning. KD was happy to present the information in the most meaningful way. It was expected that the information could be presented to the Committee in February 2015.

13. BD asked if the number of patients and pressure on beds resulted on people coming out of social care, because local authorities had cut budgets. KD replied that delayed transfers of care were often coming from social care, highlighting cases where several people were homeless and had nowhere to go. KD said that it was ‘incredibly challenging’ to move patients with challenging behaviour back into supported accommodation. RB explained that patients would stay in hospital if there was no other accommodation, because it was a place of safety, despite the fact they did not need an inpatient bed.

14. BD asked if it was possible that the trend would worsen if local authorities had to

make further cuts in 2015. KD said that they reported through IQ the service users in settled accommodation: currently they were running at 68% of their service user population.

15. KD added that the lead commissioner had asked all localities to be well-defined in terms of their detox procedures. ST understood that it would become harder to move people on after April 2015. RB was encouraged that occupancy levels were reducing towards 85%, certainly for older adults where there had been a significant drop.

QS/14/172 – CQC Updates on Progress with Compliance Actions, and Other Issues as Required

1. AM updated that five inspectors had arrived in the previous week, with a schedule of interviews for the executive team and senior colleagues. AM added that a trainee had raised concerns at the Seven Deanery Unit around the provision of Section 136 in Bristol, and had raised the safeguarding alert to the Commission. A letter had been drafted to provide the Commission with evidence and assurance around each point that had been raised in relation to the S136 issue.

2. RB asked what themes had come out of the interviews around the areas of focus. AM reported that the question, 'How do you know?' had been asked in each interview, for example, in relation to how learning from an incident in one locality was spread Trust-wide, through to how they could be assured that the learning from every green incident had been implemented Trust-wide.

3. AM said that his response back to the lead inspector had given evidence of where they had taken action immediately and where they had chosen to delay. RB understood that if an agreed process around delaying could be determined that would be sufficient. The decision to delay a red top alert in the summer around the 360 degree sweep of the room when undertaking observations, AM had decided to delay that by one week, because staff had received significant amounts of information the previous week. He emphasised the importance of not overloading staff with information.

4. In her interview, KD had been asked, 'What was the first thing you did in response to the staffing issues?' She had talked about the initiatives and pressures they had experienced in Wiltshire, and how they had mitigated that through closing beds, because there were places they could not recruit substantively. RB suggested that the question implied the Committee had not been aware of the staffing issue until the Commission had made them aware, when in fact they had been concerned for some time.

5. The localities that were interviewed were Secure Services, North Somerset and Specialised Services; they had been very well-briefed and had given a positive account of themselves. The next meeting was a feedback meeting on Thursday.

6. The first meeting with the Lead Commissioner and the TDA had been held; the CQC were invited, but did not attend. NHS England and the Quality Improvement Group had been held on 1 December 2014; the next meeting was scheduled for 19 December 2014. The corporate actions had been grouped into anti-ligature, staffing, training and supervision, detox beds, learning, medicines, policy and

procedures, and governance. There was an updated action plan for each category and progress was automatically tracked on the front page.

7. AM stated that the two reds were now amber. The staffing indicator related to expanding the bank to AHPs and Social Workers, and Chris had expedited actions around that meaning it was now orange. The other action related to a review by the responsible clinician following a serious and untoward incident, which related to the anti-ligature category, and was also now amber. There were no current reds on the corporate business plan.

8. BD asked what actions were taken in the event of a red issue. KD stated that red issues were either resolved through changing policy and procedure or they were escalated. The staffing issue was in Wiltshire; while they were doing all they could, KD did not think they could realistically change the RAG rating.

9. RB understood that staffing had been established as safe; the assurance for the Committee and the CQC was that they were providing safe care, because they had closed beds. It was necessary to articulate the information in a way that the CQC were able to understand that patient safety had been maintained, despite staffing and recruitment difficulties.

10. ST asked for an update on Wiltshire in terms of how the staffing issues had been managed. DC outlined that beds had been closed because it had not been possible to provide even agency staff to man the unit. DC explained that they had reduced Beechley Dean to 16 beds, but they were still below safer staffing levels, still had to utilise agency and bank, but the risk was reduced.

11. DC hoped that the staff in that unit felt supported, because they were feeling pressure due to not being able to give service users the attention they needed. A ward manager for Ashdown had recently been recruited. ST asked DC to outline the impact on access to beds and community services. DC outlined that they had fewer out-of-areas than when the ward was running at full capacity; beds were being actively managed, as well as the patients within them. Additional resources were funding two workers doing out-of-area work and a business case would be put to maintain that.

12. AM added that several safety issues around capacity and the consequences of capacity: a joint letter with the Medical Director from Somerset Partnership had been sent to NHS England about the capacity issue. The Directors of Nursing for the South West Peninsula would be writing the same letter to NHS England. Next month the Expert Patient Safety Group that advised NHS England would write about capacity concerns to NHS England.

13. One corporate work stream centred on ligatures. With regard to formulating a risk-based approach to suicide, AM updated that several background factors had been reviewed. Review of incidents since 2006 shows the en suite doors were the main ligature, and other fixed ligature points in lower numbers had been identified. The Trust were not an outlier in the National Confidential Enquiry with regard to in patient deaths or any indicators apart from two, which was more people who had a history of self-harm had killed themselves.

14. The biggest preventive factor was the availability of inquisitive and intuitive staff. The biggest cause of harm to inpatients was falls.

15. AM outlined that a risk-based approach had been undertaken. Audit standards would be applied to the wards, to ensure that their tolerance of ligature in some services was justified. Services had been defined in three levels: high risk, lower risk and lowest risk. The lowest risk identified was dementia care where falls remained the highest cause of injury.

16. The audit tool was being piloted in the current month; the audit would look at requirements in each ward. After the tool had been approved, each ward would be audited across the organisation to test compliance. AM confirmed that the tool testing had been completed. They were finalising some procedural tasks, with front line staff attending a workshop to determine Trust-wide procedures in relation to removing a ligature to and from a patient, the allocation of anti-ligature rooms, and standards by which they would respond to risk identification.

17. Information would be published Trust-wide, so that it could begin to be used. KD explained that the standards were set by the Clinical Executives and the experts in the field; those standards were given to operations and then plans were created per locality with higher risk wards being the priority. Once the team was satisfied that they had affected changes in accordance with requirements, the Clinical Executive would carry out checks.

18. ST asked whether the Quality Board would ratify the standards. AM replied that the Suicide Prevention Group was an identified network that would come under the auspices of the Quality Board, and the Ligature Group was a subset of that. The Suicide Prevention Group would be held to account by the Quality Board, as would all other networks. Terms of reference for the Quality Board were due to be drafted by AM, Emma Roberts and Dan Meron.

19. ST asked when the process would be completed. KD explained that the review paper in respect of money had been received by Operations the previous Monday. KD thought that plans for highest risk areas would be underway between January and March. AM added that several actions had been commenced ahead of schedule. The information would be presented to the Committee as a formal update, and would be included as part of the CQC Improvement Update provided by KD.

20. ST asked if the current action was indicative of how other concerns on the risk register were being addressed through systems and processes. KD replied that the heat map was updated on a fortnightly basis, and was submitted to the TDA on a fortnightly basis. AM stated that for each of the themes there was an executive lead; for example, Hayley had insight on the medical actions, and KD had insight on the detox and beds issues. ST reminded those present that the Committee had been criticised for not being sighted on follow-up actions. AM and KD confirmed that each corporate action plan had a named lead. ST felt the plan was robust.

21. AM added that it was necessary to keep reviewing the delivery dates. The TDA had advised to set long-term delivery dates in order to ensure that all actions were completed to deadline.

22. ST suggested that the Committee continued to struggle with some of the basics in terms of compliance—observation practice, person centred care plans—which was frustrating. RB felt it was moving from reacting quickly to adverse inspections to

being a proactive Trust that ensured those things did not happen through having good practice. The Trust had reacted quickly and positively to the CQC report, but that had to be moved into 'business as usual'.

23. ST noted there had been huge improvements in the focus on physical health, but that the issue remained amber on the work plan. ST suggested that the amber rating could be due to people reporting wrongly or a couple of outliers, but it remained disappointing despite being a key priority. ST felt they should think about what effort was being put into the top five, were they going to get them right and would they turn green. AM understood that the top effort would be in security the workforce and the quality of the workforce; the incident rates of any team was related to the skill-set and leadership of the team leader. RB stated that the staffing and leadership development issues were a major focus of ESEC. ST thought it would be helpful to reflect on whether they were recognising changes in acuity of service users in patient and community services.

QS/14/173 – Work Plan Discussion

1. ST emphasised the importance of linking with the report from Ray Tarling, which set out how the Committee should be operating and supporting the Board in terms of the quality agenda.
2. ST suggested that August was not an appropriate time to host a locality presentation and proposed that the Bristol presentation be moved to May.
3. The clinical strategy progress against objective and Medicines Optimisation Strategy were noted as 'annual'. ST suggested that a quarterly report was necessary for medicines for sufficient assurance around medicines management and strategy overall through the past year. AM replied that it had been agreed that corporate plans would be updated by the Check and Challenge process, which could provide more frequent assurance and evidence around the progress of specific actions.
4. ST noted that there was no direct reporting from Management Groups. It was discussed that management groups would feed information as and when required into the relevant reporting areas, reducing the need for individual reports to be made.
5. ST suggested that one report would be sufficient otherwise they would get too involved in operational issues. AM was mindful that there was an external audience in terms of contractual reporting, so some of the reports fulfilled two functions. RB understood that the issue was largely operational; she emphasised that Committees should be more specific about assurance and the evidence required. AM proposed that he, Hayley and LH could review the suggestion and that guidance could be provided to the groups.
6. KD proposed that the top Clinical Directors' locality presentation be coordinated so that they were dovetailed in with the week in focus, the first of which will be run in the first week of February and debrief into the Committee that month, as well as their action plan be placed on the agenda the following month.
7. ST requested more accessible venues with particular focus on public attendance. ALB assured ST that work was being done in finding venues for 2015/16. KD

further noted that she and AM had discussed having a more structured exception report for the localities.

8. KD requested some capacity through the year to look at a service line, as opposed to just a locality, through AM's Quality Assurance Team. ST hoped they would be looking at Quality Improvement Plans for localities in March. AM added that the CQC action plans needed to become the Quality Improvement Plans as a more appropriate living document.
9. ST asked AT to produce a briefing document for the next meeting, to brief localities on what was required of them in February and March meetings. . RB felt this was about escalating issues to the Committee out of the normal reporting schedule.
10. The medicines management report was requested six-monthly.
11. ST turned to the terms of reference within the work plan. She suggested that it was important to state that the Committee were reviewing Quality and Improvement, as well as Compliance.
12. ST added that she expected localities to be available to attend if requested, or to add items to the Committee's agenda that were on their risk register.
13. ST added that the terms of reference needed to take account of the proposed Quality Board, and how assurances would be communicated to the Committee.
14. ST suggested that the Committee meet 10 times a year, rather than 12. However, it was requested that 12 dates are booked as a fall-back.
15. KD noted that at the previous seminar, it had been agreed that the Nursing Director would be the lead executive for the Committee. This was confirmed. Further, the terms of reference did not make reference to KD, who was present at every meeting in an attendee capacity.
16. RB asked that revisions considered items 7 to 11 being summarised as bullet points under item 6, as 6 was the all-encompassing item. KD requested that it be added to 6 that, 'these processes are evidenced through appropriate outcomes'. It was also requested that they include, 'improve quality of service to service users and carers'.
17. Those present agreed that the August meeting would be cancelled. ST added that it was further possible to reduce the number of individual reports sent to the Committee, in order to increase the potential time to be spent on completing business and finalising actions.

QS/14/174 – Policies (Tertiary Physical Intervention Policy)

1. AM presented the changes to the Tertiary Physical Intervention Policy.
2. ST asked AM to clarify the purpose of the policy. AM replied that under the Crisis Concordat the purpose was to provide a non-police place of safety for children under 16. The Mason Unit had been redesigned, the safeguarding procedures had been explored, and standard of response for the CAMHS provider had been established.
3. ST asked if a designated safeguarding lead had been designated for children in medical and nursing. AM replied that was correct. The CAMHS provider had to

provide the main response to the admission; it required the loss of one of the rooms, so that the young person could be segregated from adults in the unit.

4. AM noted that changes had been approved to the ways in which restricted practices would be recorded, which would allow them to identify the use of supine and prone restraint in a planned and unplanned way. It was hoped that this would lead to an easier way of capturing all the interventions that were used in one event
5. The policy was approved.

ESEC/14/060 – Any Other Business

1. LH updated that quality improvement visits would cease at the end of the month, and would be replaced by a range of different inspections. There would be a locality quality walk-around, which would have a different topic for each week of the month. This would be supported by executive-led quality walkabouts. There was a programme of unannounced visits that would take place continually through the year. These would be supported by week in focus compliance inspections. The learning would go onto the safety patient development plan. The first week in focus inspection would be held in the first week of February.
2. ST asked to what extent external benchmarking or peer review was being employed and asked whether they were looking at best practice to bring learning back into the organisation. LH replied that the week in focus inspection details were being finalised. LH said that she had not intended to include specialists from other organisations, but could look at this.
3. KD confirmed that they benchmarked themselves against similar organisations, and that the benchmarking club used this information to see where the Trust sat and who was better in certain areas. ST felt they should be involving service users and carers in these visits.
4. DC added that it would be valuable for frontline staff working on the units to undertake visits, to have visibility of the changes required and facilitate the embedding of those.

ESEC/14/061 – Agree Any Items to Escalate to Board, or for Horizontal Reporting to Other Committees

1. ST highlighted the issue around risk appetite and staffing, which the Board was already sighted on.
2. To refer to F&D the recommendation that a review and evaluation was completed of the implementation of mobile working.