Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

Minutes of a Meeting of the AWP NHS Trust Board

Held on 28 January 2015 at 10 a.m. in the Conference Room, Jenner House, Wiltshire

These Minutes are presented for **Approval**

Members Present

Tony Gallagher – Chair
Ian Tulley – Chief Executive
Peaches Golding – Non-Executive Director
Ruth Brunt – Non-Executive Director
Kristin Dominy – Executive Director of Operations
Lee O'Bryan – Non-Executive Director
Sue Hall – Executive Director of Resources
Dan Meron – Deputy Medical Director
Barry Dennington – Non-Executive Director
Alan Metherall – Acting Executive Director of Nursing

Staff In attendance

Graham Coxell – Associate Non-Executive Director
Dr Simon Manchip –Clinical Director, Swindon Locality
Emma Roberts – Director of Corporate Affairs and Company Secretary
Rachel Clark – Director of Organisational Development

Members of the Public in attendance in the gallery

Mr S King - Patient
Mr D Ody - Patient
John Ridler - AWP
Rebecca Paillin - AWP
Simon Gerard - AWP
Emma Bye - AWP
L Reeves – Wiltshire and Swindon Users Network
Jo Collins - AWP

Dementia Care Presentation by Dr Simon Manchip

1. SM gave a presentation on dementia care in the Swindon locality.
2. He characterised acute hospital admission as a negative situation for dementia patients; rather, dementia should be seen as a chronic primary care condition affecting the old and frail, which is the core work of GPs. The last 15 years of research have failed to produce any new dementia treatments, and, with demand far exceeding supply, the care and support element of memory services has been compromised. There is a drive by NHS England to increase the percentage of dementia sufferers registered with a GP: over three months, Swindon has increased this from 48% to 62%.

3. Currently, there is an average eight-month wait for a dementia assessment, with diagnosis following two months later. Dementia diagnosis is vitally important, but must be simplified; 80% of GPs referring there already believe the patient has dementia.
4. A shared care protocol for donepezil has been implemented, the cost having been significantly lowered. GPs are now doing repeat prescriptions, with a few surgeries diagnosing. There is agreement between the locality and the CCG as to moving the majority of dementia treatment into primary care, with significant secondary care support.
5. A vital priority is the improvement of the care home experience, making a patient's experience in the last months of a high quality. Swindon has seen some success, with low rates of anti-psychotic tranquillisation and work on pain management.
6. BD inquired about the lack of new treatments nationally. SM explained that research has been focused on soaking up amyloid in patients' brains; this has not proven beneficial, as the amyloid is likely to have been laid down 15 years before a person develops dementia. However, evidence shows that treating cardiovascular risk factors can make a difference.
7. LOB asked SM to summarise the shift required in terms of skills and capabilities. SM replied that the proposal is to develop a training programme for GPs but also provide them with an advice point to call.
8. GC asked whether there are opportunities for self-help on the internet. SM confirmed that primary prevention was a focus; cholesterol treatment, smoking cessation and obesity reduction could reduce the chances of dementia by 30%.
9. RB asked whether the Board should be offering more support in determining future strategy. SM asserted that to continue supporting the current model would be to continue supporting failure. This was a national drive and the Board could help with some of the threats over the horizon. Secondary care's role should be in provision of expertise, with memory service treatment dedicated to atypical and younger patients.
10. DM noted the potential to obtain funding and raise profile through engagement in upstream work. SM observed that care homes are happy to pay for training; a recent workshop on pain management in dementia attracted over 500 delegates.
11. AM highlighted the current debate around whether specialist or general nurse training is optimal to address the complex care needs of frail people with dementia. SM observed that the average RGN has four hours of dementia training in three years.
12. The Board thanked SM for his presentation.

BD/14/28– Apologies

13. Apologies were **received** from:

Tony McNiff – Non Executive Director;

Hayley Richards – Executive Medical Director;

Susan Thompson – Non-Executive Director.

BD/14/249 – Declaration of Members' Interests

14. There were no changes to members' interests to be notified.

BD/14/250 – Questions from Members of the Public

15. No written questions had been received from members of the public.
16. A member of the public present asked about the timescales for Trust staff to reply to correspondence. ER stated that it would depend on the type of correspondence. A response will be provided outside the meeting.

BD/14/251 – Minutes/Summary of the Meeting on 17 December 2014

1. Page 1: PG was listed as present, but had been absent and sent apologies.
2. Page 5, point 12: it should be clarified that the £8 billion gap was national.
3. Page 6, point 3: the tariff reduction should be stated as 1.55.
4. Page 8: under 'Report of the Committee Chairs', the first part of item 2 should be transferred to item 1; item 2 should start, 'The learning and development team had been able…'
5. Page 9, point 6: LOB asked that 'assured' replace 'completely confident'.

BD/14/252 – Matters Arising

1. A proposal for the next phase of system leadership is in the process of being agreed with the CCG. ER noted that a presentation has been arranged for the February meeting.
2. The LIFT and Alcohol Services report will be brought to the Board in February. KD reported that the issue raised at Finance and Planning Committee had been resolved. LOB felt there should be a discussion regarding commercial strategy.
3. SH confirmed that the finance paper had been updated.
4. ER said that the segmentation of the trust-wide risk register had not happened, given the new approach taken in this month's risk paper.

BD/14/253 – Chair and Chief Executive's Actions

1. The Chair reported that there were no actions outstanding.

BD/14/25 – Chair's Report

1. The Chair's presented his report, highlighting that the four warning notices issued by the CQC in September 2014 had been lifted, but improvements needed to continue in the coming year.
2. The Chair advised that the changes required in response to the Dalton Review and Five-Year Forward View would likely fall within the calendar year, and any organisational strategy change will need to be considered over a shorter timeframe than anticipated. The Board has put a task and finish group in place to progress

the actions and report back.

3. The Chair had attended the annual Nursing Conference and thanked the organisers for a successful day.
4. Having met with Swindon CCG, the Chair reported that they wish to develop a long-term one-to-one, rather than third-party, relationship with the Trust. The CCG are positive about the Trust's handling of the crises in Swindon over the Christmas period.
5. The Board resolved to **note** the report.

BD/14/255 – Chief Executive's Report

1. IT reported that the Bristol Health and Wellbeing Board had recently held a summit and was considering inviting provider organisations to become part of the Wellbeing Board, to play a part in developing the health and social care system for the city.
2. He reflected that the Trust is experiencing the highest level of sickness it has seen in 18 months. There appears to be an issue around long-term sickness, and the Trust is working to understand whether this represents a continuing trend.
3. Turning to the Five-Year Forward View and the Dalton Review, IT felt that these broadly reinforced the importance of the Trust's structure in terms of clinical leadership, local integration and partnership within the community. However, it is vital to be as close to the ongoing discussions as possible. Stephen Dalton, Chief Executive, Mental Health Network, will join the Board seminar in February to talk about the emerging thinking in mental health and how Trusts like AWP should positively respond to the future structure of the NHS.
4. The Trust is involved in a zero-suicide collaboration across the South West, with Anthony Harrison as the Suicide Lead. The first regional event had taken place the previous week.
5. IT highlighted the variations in financial allocations between CCGs, representing an attempt to bring areas furthest away from their targets closer to them. He noted that there would be another challenging planning round for CCGs.
6. IT concluded by highlighting that recent Team of the Month nominations from local areas had been impressive, with any one of the nominees being a worthy winner. Staff in the inpatient, intensive and Section 136 teams in Devizes were praised for remaining positive and committed to care, in the face of difficulties including a number of assaults on colleagues by service users.
7. The Board resolved to **note** the report.

BD/14/256 – Finance Update

1. SH reported that the surplus position in month 9 of £333,000 represents an £80,000 improvement over the projection, primarily due to income received from CCGs for additional one-to-one nursing. However, significant additional cost pressure is being seen on the year-end forecast position.

2. Major areas of concern include: the significant rise in the cost of agency staff, which are still utilised due to recruitment difficulties; continued high staff turnover; two additional cost reduction plans having failed to materialise; and the lack of additional funding to manage CQC requirements.
3. An urgent review of all rosters has been undertaken to ensure compliance with the rostering policy. KD noted that a new roster system had been implemented at the beginning of the year to enhance visibility on how teams and wards are working and enable them to challenge bank and agency requests.
4. SH reported that central clinical support is being directed into localities, to reduce reliance on agencies. Additional pharmacy agency staff will no longer be used; internal ward pharmacists will be reallocated to facilitate this. SH had requested that all LDUs ensure they are forecasting on a real rather than worst-case basis.
5. The Finance and Planning Committee had reviewed the proposed cost reduction plans the previous week and there is confidence with respect to the year-end position.
6. BD asked what variation in staffing costs was budgeted for. SH explained they had not budgeted for any agency premium in 2014/15, though had done so for the first quarter of 2015/16. However, recruitment levels must be addressed.
7. RB asked how sustainable the mitigations were. SH emphasised that actions such as increased control over rostering and reduction in agency use are not only about year-end position, but will be in place going forward. The Recruitment Strategy working group will continue to meet every fortnight. IT added that Pharmacy had devised a plan to restructure clinically and operationally, addressing the need for agency staff. The restructure has been agreed in principle and will be implemented by April.
8. PG asked about incentives for appointment in areas struggling with recruitment. SH responded that it is the responsibility of localities to determine what works best in their area. Secure Services are proposing a six-month 'golden hello' incentive for Band 5 and Band 3 staff, while Wiltshire are considering putting accommodation in place for workers. A 'refer a friend' scheme is being implemented across the Trust.
9. GC asked about localities' autonomy to pay retention bonuses to grades that were hard to recruit to. IT commented that this would depend on affordability and need. Agency usage more broadly would have to be addressed in conjunction with other Trusts. There was a Health Education England initiative to train and retain nursing staff. IT emphasised the need to maintain a focus on being a good employer.
10. AM highlighted that NHS England would be taking the lead on workforce issues. The Trust should pay attention to possible unintended consequences, such as attracting nursing staff away from homes.
11. The Chair requested quantified cost savings on areas of mitigation in advance of the next financial year.
12. SH outlined the minor changes to the balance sheet, mainly related to the reprioritisation of the capital programme to fund CQC works in year. Certain

planned disposals had not gone ahead, mainly for operational reasons. The capital resource limit would be on target. A risk assessment had been undertaken on changes to the capital programme, to ensure they would not have significant impact on operational delivery. The risk rating remains at 3.

13. SH noted there is no guidance on pay costs, but they had assumed a 1% increase. High reference costs remain a concern, and a sub-group has been created to examine the issue in detail. The Chair expressed concern at the lack of a reference point to determine when to escalate recruitment risk to the commissioner, and requested this was resolved.
14. LOB drew the Board's attention to the impressive performance in terms of cost improvements in this year. We have seen improving delivery over the last two years with all CIPs being delivered in a timely and disciplined way.
15. The Board resolved to **note** the report.

BD/14/257 – Quality and Performance Report

1. KD drew attention to the suspension of the current regime of self-assessments. The new reporting process would be in place from February onwards.
2. Performance challenges in respect of Bristol and Swindon have been addressed through Committee meetings, and management actions put in place. Additional authorisation processes have been implemented to ensure complete oversight of care and management of out-of-area patients.
3. In relation to safer staffing, KD detailed that night visits to Fromeside had taken place, during which the staffing challenges had been clear. A procedure would be implemented to sign off on the contribution of any agency staff, given concerns about the quality of their work.
4. KD had expressed dissatisfaction with the performance of localities in respect of rostering; she expected to see significant improvement against KPIs.
5. The Chair asked how to interpret the data showing planned and actual hours. RB noted that this point was raised at the meeting of the Employee Strategy and Engagement Committee this month and there is work ongoing to look at how they assess work pressure from over-staffing as well as under-staffing.
6. The Chair noted that the issue of bed management should be brought to the Finance and Planning Committee before the Board, as there are some 'easy wins' to implement. **ACTION**: **KD**
7. IT commented that the current reduction of beds would have no financial impact for a temporary period, because the Trust has retained staffing levels in order to improve quality in those areas where capacity has been reduced. This will be a matter that will need to be addressed in the current planning round.
8. The Board resolved to **note** the report.

BD/14/258 – Quality Improvement Plan

1. KD brought the two exceptions to the attention of the Board: staffing in Wiltshire

and single-sex accommodation, where issues had been identified on ward 4 of St Martin's Hospital. This had been escalated to the commissioners, who were undertaking further review.

2. The Board resolved to **note** the report.

BD/14/259 – Trust-wide Risk Register

1. ER presented the revised Trust-wide risk register. She outlined the proposal to divide the risk register into a monthly risk register reporting operational corporate risks and a quarterly strategic risk register. She invited views on the proposals.
2. RB commented that the new format was better. LOB sought clarity on what the approach would be with regard to committees. ER explained that they proposed to divide the risk by committee, linking each committee to strategic priorities and risks.
3. The Chair noted that the Audit and Risk Committee had been concerned that risk registers are not used in a sufficiently dynamic way; risks are being added but not removed, giving limited assurance as to the efficacy of mitigation. It was intended that this approach would help to manage these concerns.
4. The Board resolved to **approve** the changes to the reporting of the Trust-wide risk register and **note** the report.

BD/14/260 – Board Assurance Framework

1. The Board Assurance Framework was presented for the Board to note.
2. ER explained that they will have a total refresh of the board assurance framework for 2015/16, to make it more externally-facing and reflective of the Trust objectives and priorities.
3. The Board resolved to **note** the Board Assurance Framework.

BD/14/261 – Annual Objectives

1. RC presented the annual objectives, noting that they had been taken through a range of committees and groups to review and revise. Objectives are outcome-focused, and every locality will have the opportunity, in consultation with staff, to determine how they can achieve them.
2. BD asked how they would dovetail the objectives with the appraisal and objective-setting process for individual staff members. RC responded that the first stage would be a discussion with the localities, who will then engage staff as to the form the objectives take at team level.
3. RB stressed the need to set incremental corporate targets in line with long-term objectives. It was suggested that the absolute baseline for each objective be added to the paper, so they could establish the required monthly and quarterly reductions.
4. DM suggested that they link organisational objectives directly to organisational risk registers. ER stated that the ambition is to combine assurances, priorities and risks together so they align to provide effective business information and integrated

assurance.

5. BD remarked that the ultimate test is whether any individual in the Trust can link their objectives to the corporate objectives. He suggested viewing a small sample of appraisals and objectives to establish how far this holds true. The Chair requested a review of the localities' interpretation of objectives before the end of the year. RC replied that that would be possible.
6. GC commented that the objectives were internally focused, and questioned where they helped the Trust achieve the five-year plan. The Chair stated that one specific objective is that the Trust would grow by £4.2 million. IT added that he did not want the front line to be worried about Board growth strategy, but focused on ensuring all delivery requirements are met. The actions led from the need to include in our objectives our external intentions. It was noted that clarity was required around the respective roles of localities and the centre in achieving this growth.
7. On staff development, the Chair remarked that a 10% improvement in responses did not address qualitative aspects. He questioned whether a 2% reduction in staff turnover was too limited an aspiration. It was noted that reference cost reduction should apply more broadly, rather than just to community. The meaning of 'enterprise strategies' needed to be made clearer.
8. GC asked where the aspiration to become a Foundation Trust was captured as an objective. SH replied that they had decided not to make an explicit reference to this, given the potential for changes arising from the Dalton Review. The Chair commented that, if they achieved the objectives, they would be a sustainable and well-led quality organisation, the hallmarks of a Foundation Trust.
9. The Board resolved to **approve** the annual objectives for 2015/16 subject to amendments referred to above.

BD/14/262 – Report of Board Committee Chairs

Employee Strategy and Engagement Committee

1. RB presented the report, highlighting that the Committee had received a promising first draft of the quarterly HR report, providing the finer detail underlying metrics such as sickness absence.
2. A two percentage point reduction in turnover had been agreed as a target, in line with the benchmark of other mental health trusts, but this could be increased over the year. IT asked whether a stretch target had been considered for the areas with the greatest challenge. RB replied they had discussed breaking the target down across localities and this would be addressed in the next quarterly report. The Chair remarked that there are problems across most of the Trust. However, specific issues need to be looked at in each area.
3. The Committee had reviewed the detail behind reasons for staff leaving posts. A large group categorised as 'other' was not understood well enough, so clearer data is needed to support retention actions. The Chair emphasised that they should be clear as to whether trusts were calculating turnover using the same parameters.

RB highlighted that they also needed to adjust for significant events such as contract changes.

4. An early indication of staff survey results showed a mixed picture. 8% of scores had improved, particularly in terms of staff having had appraisals and access to training, but 15% of scores had deteriorated. Work on staff engagement needs to continue. An action plan would be brought to the Board. LOB asked what the response rate was. RB said that it had increased from 48% to 51% of all staff.
5. The key risks are sickness absence, sustaining statutory and mandatory training compliance, bank/agency staff and turnover.

Finance and Planning Committee

6. LOB presented the report of the Finance and Planning Committee. He observed that there is still work to do in terms of preparation work for committee meetings.
7. There is a concern that the higher costs of agency staff had not been recognised beforehand. The issue of locality/central decision-making needs to be revisited.
8. LOB recommended conducting a review of whether the capital plan spending remains relevant. The Swindon deep dive review had been useful and produced actions for the Executive Team. The Hill View replacement will proceed to planning.
9. GC inquired as to progress with the IT system replacement. SH said that there is a lot of work to do, but it is going ahead.

Audit and Risk COmmittee

10. The Chair presented the report of the Audit and Risk Committee. Secure Services had demonstrated effective use of risk registers.
11. The Grant Thornton External Audit managerSimon Garlick would be replaced by Barrie Morris.
12. Timely management response to Internal Audit reports was highlighted as in need of improvement. The CQC had interrupted the flow of internal audit, so it is crucial to ensure it comes back on track in a managed way.

Quality and Standards Committee

13. RB presented the report of the Quality and Standards Committee. There had been a deep dive into Secure Services' quality issues; a new system had been presented for rapid tracking of quality, safety and risk issues and action taken in response. Recruitment had improved and the quality impact of the ward closure had been discussed.
14. A verbal report had been received from Bristol with assurances around service quality; the Committee had requested a formal QA review once the transition period was over.
15. There was concern at the limited progress in reducing restricted practice over the last year, although a lot of groundwork had been completed. The Committee had requested a trajectory of improvement for the coming year.

16. A report on physical health interventions had also been received. The Trust had a high incidence of falls and pressure sores. The Committee had issued a challenge around zero tolerance of harm. The Chair noted that Pharmacy have been tasked with investigating the correlation between falls and medicines management.
17. Wiltshire LDU has been invited to attend the following meeting to provide assurance. IT reported that, in view of current challenges in Wiltshire, the triangular review has brought forward and will become the subject of greater support and focus.
18. The Chair noted that sustainability had been an issue for the Swindon locality
19. The Board resolved to **note** the reports of Committee Chairs.

BD/14/263 – Minutes of Board Committees

1. The minutes were taken as **read and approved**.

BD/14/264 – TDA Oversight

1. ER commended to the Board the TDA submissions, which had been assured by the Finance and Planning Committee.
2. The Board resolved to **approve** the submissions.

BD/14/265 – AOB

1. SH reported that access issues with the RiO national spine and the Trust's U: drive two weeks previously drive had called into question the Trust's disaster-recovery plan and highlighted the poor practice of staff storing files on unsecured local drives. IT undertook to bring a full report of the investigation to the Board. **ACTION: IT**.
2. DM stated that two consultant psychiatrists were currently excluded pending disciplinary processes and a middle-grade doctor had been suspended by the GMC. The GMC had removed the conditions imposed on the doctor's practice, but the Trust had agreed to continue as if those restrictions were in place.
3. ER undertook to coordinate the receipt of incident information via the Chief Executive's Report from February onwards.
4. There being no additional business, the meeting of the board in part one closed at 12.35pm with the board to reconvene in part two at 1pm.

> The Board resolved under the Public Bodies (Admission to Meetings) Act 1960, to pass the following resolution:
>
> "That under the provisions of Section 1(2) of the Public Bodies (Admission to Meetings) Act 1960, the public be excluded from the remainder of the meeting on the grounds that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted."

Non-members of the Board were asked to withdraw from this point forward.

Abbreviations
CQC – Care Quality Commission
CCG – Clinical Commissioning Group
BNSSG – Bath, North Somerset and South Gloucestershire (CCG)
TDA – NHS Trust Development Authority
CSU – Commissioning Support Unit
RMN – Registered Mental Health Nurses
HCA – Health Care Assistant
FTN – Foundation Trust Network
CIP – Cost Improvement Plan